

# PUBLIC HEALTH IMPROVEMENT PLAN

2004



Always  
working  
for a  
safer  
and  
healthier  
Washington

# A VISION FOR WASHINGTON'S PUBLIC HEALTH SYSTEM

Washington State's public health partners envision a public health system that promotes good health and provides improved protection from illness and injury for people in Washington State.

To help realize that goal, the public health system is committed to:

- Focusing our resources effectively, defining and monitoring **outcomes** for key public health issues and trends, and emphasizing evidence-based strategies.
- Maintaining a results-based **accountability** system, with meaningful performance measures and program evaluation.
- Using a method of **funding** across the public health system that is stable, sufficient, and equitable.
- Using standard **technology** across the public health system.
- Maintaining a **workforce** that is well-trained for current public health challenges and has access to continuous professional development.
- Facilitating discussions about health care **access** and delivery issues from the perspective of community systems, where the experiences of patients, providers, purchasers, and payers are considered important components.
- Applying **communication** strategies that are effective and foster greater public involvement in achieving public health goals.
- Establishing new coalitions and alliances—among stakeholders, policy makers, and leaders—that support the mission of public health.

The *2004 Public Health Improvement Plan* summarizes the work of many people who have joined efforts in committees and work groups. More detailed, full reports are available.

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**PHIP 2004:**

# **TRANSFORMING PUBLIC HEALTH IN CHALLENGING TIMES**

December 2004



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## PHIP on-line:

[www.doh.wa.gov/hip](http://www.doh.wa.gov/hip)

**PUBLIC HEALTH**  
ALWAYS WORKING FOR A SAFER AND  
**HEALTHIER WASHINGTON**





Dear Friends of Public Health:

It is a pleasure to introduce the 2004 Public Health Improvement Plan, *Transforming Public Health in Challenging Times*. This work is the product of a truly remarkable partnership among many people who are always working to create a safer and healthier place for all of us in Washington State. They include local public health officials, state health officials, the School of Public Health at the University of Washington, and the Washington Health Foundation.

The Public Health Improvement Plan (PHIP) was established in legislation in 1993 and is to be presented to the legislature every two years. The legislation called for the public health system to meet standards and analyze what it will take to meet those standards, in terms of budget and staffing. In 1995, legislation called for assessment of the public health system and identification of what is needed for “the public health system to fulfill its responsibilities in improving health outcomes.”

These requirements are the underpinnings of a continuous effort to improve the health of people in every community throughout our state. The cooperative effort of our PHIP Partnership has created a stronger public health network, despite a critical shortage of resources. Through the PHIP, the public health partners have set a clear vision for a healthier future and created a strategic plan to bring it about. Along the way, we have developed a health report card, set performance standards for state and local public health jurisdictions, estimated the costs of achieving those standards and evaluated what must be done to respond to challenging issues in our workforce, with information-technology, and with access to health services in our communities.

Our state is fortunate to have a workforce of dedicated public health professionals who work to protect and improve the health of people everywhere in Washington. I extend my thanks to everyone who has a hand in making this partnership work. I look forward to seeing the recommendations in this report fulfilled, as we realize our hopes for safer and healthier Washington.

Sincerely,

Mary C. Selecky  
Secretary of Health

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# TRANSFORMING PUBLIC HEALTH IN CHALLENGING TIMES

We live in times that have conditioned us to think seriously about what it takes to be healthy and safe.

Our communities are becoming more crowded, more closely linked through travel, trade, and technology. As globalization increases, we face the threats posed by both new and re-emerging diseases that have greater opportunity than ever before to make their way around the world. As growing populations demand more resources, the quality of our air, water, and food is increasingly threatened. And since September 11, 2001, we have recognized and prepared for new threats to our safety, such as those posed by bioterrorism.

It seems the world moves faster and everything is more complicated—even a trip to the grocery store is not as simple as it appears to be (see box, page 8).

For each of these new challenges, the public health system plays a vital role in protecting people from harm while taking steps to reduce the health impacts felt in our changing world. The public health *system* is a network of agencies that are “always working for a safer and healthier Washington.” This work engages government agencies—at the state and in 35 local public health departments and districts—and a public health workforce of several thousand people, who work with thousands more researchers, scientists, health care providers, and other community partners.

In this sixth biennial report of Washington’s Public Health Improvement Partnership (PHIP), we focus on the activities that are underway to keep our state’s public health system performing to the best of its ability. In many respects, the activities associated with the PHIP since its inception in 1994, as an ongoing requirement of the Washington Legislature (RCW 43.70.520), have shaped the public health system today. The PHIP has moved us from a loosely associated group of government agencies focused on specific programs and clinical services to a closely integrated and coordinated system. Each local agency continues to serve the needs of its own community, but through the PHIP, Washington’s public health leaders also work in concert to set a vision for the future, to focus on public health priorities, and to direct dwindling resources to where they are most critically needed to improve and protect health.

Remarkably, this transformation has occurred during the course of a long slide in funding for public health, one that continues to undermine planning and weaken the infrastructure. During this time, the state and national economy have slumped into recession. The dedicated funding sources that once sustained public health work have nearly disappeared. Since September 11, 2001, new resources have come into the state to combat bioterrorism, but they cannot support the improvements—in surveillance, technology, and workforce expansion—that today’s more complex public health environment demands.



*The PHIP has moved us from a loosely associated group of agencies focused on specific programs and clinical services to a closely integrated and coordinated system.*

## The need for vigilance

The year 2003 closed with the nation's attention riveted on Washington State: A case of "mad cow" disease had been linked to a farm in our state—a case that had potentially profound implications for public health and instant impact on agriculture. Within minutes, the positive test result set off a national response that linked Washington's health and agricultural communities with the nation's top scientists and policy makers. In the days and weeks that followed, new protocols were adopted for

monitoring cows, and the entire industry geared up for increased testing and tracking of animals.

Maintaining vigilance is the key to protecting the public's health. BSE—or mad cow—disease is an emerging threat, but as the box on page 9 points out, we cannot afford to turn our backs on old threats. They will re-emerge if left unattended. Public health measures such as immunizations and tracking and treating communicable disease are just as vital today as they were at the turn of the century in 1900.

## Keeping Our Food Supply Safe to Eat

In the 1950s, your typical neighborhood grocery store carried about 300 different food items, many of them produced locally. Today, a supermarket routinely carries about 30,000 various food items from around the world, reflecting both the scale of corporate farming and the reach of the global economy. Interestingly enough, with this wide variety of foods available for home preparation, people eat out more, sustaining a restaurant industry that does more than \$300 billion worth of business a year. And hot foods, ready to serve, are commonplace at neighborhood grocery stores.

This evolution of the food supply, food service industry, and customer behavior has put extraordinary pressures on public health food safety programs, which must adapt to new causes of food-borne disease outbreaks and the illnesses they cause. In Washington State, 1.5 million food-borne illnesses occur each year, including 6,500 hospitalizations and nearly 100 deaths. This year, the state Department of Health Division of Environmental Health worked with the State Board of Health to revise the state's food service rules. The new rules incorporate the latest scientific information about safe food handling from the federal Food and Drug Administration's Model Food Code (see <http://www.doh.wa.gov/ehp/sf/food.htm>).

In the past decade, the primary cause of food-borne illness was holding food at an improper temperature—most often food allowed to cool in too large a container or not cooked thoroughly. This was the cause of the well-known case in our state in 1993 linked to fast-food hamburgers that contained the bacterium *E.coli* 0157:H7. In response, rules and training focused on temperature control. Today, the most common cause of food-borne illness is inadequate hand-washing by food service personnel. The new rules will prohibit bare-hand contact with foods that are ready-to-eat, continue to stress the importance of hand washing, and more clearly define when an ill worker must be restricted from the kitchen.



## TB: Fighting an Old Public Health Battle

Two global trends—the ease of travel and an increase in congregate living—are driving up the numbers of people affected by old scourges that were once thought to have been conquered by public health and medical interventions.

One such scourge is tuberculosis, with which a third of the world's population is now infected. TB was once the leading cause of death in the United States, but its incidence dropped steeply for four decades with improvement in living conditions and development of drug therapy in the 1940s. With the rise in immigration, homelessness, and immune-suppressing conditions such as HIV, TB has re-emerged since the late 1980s with a vengeance among homeless and immigrant populations and also among other risk groups such as the very young and the elderly.

Washington, which experiences more than 250 new TB cases in a year, is one of about a dozen states with TB rates above the national average. King County, which has experienced several outbreaks since 2000—some among homeless, foreign-born men—reported its highest number of cases (156) in 30 years (2003). Another significant outbreak occurred in Yakima County in 2003, this time concentrated among the native-born.

People can feel well enough even with active TB infection to work and attend school, but they begin to feel ill when they take the powerful drugs to treat it. For this reason, many patients discontinue the months-long treatment, a situation that forces public health agencies to implement costly and time-consuming directly observed therapy.

A root cause of the new wave of TB outbreaks is poverty and the rising number of uninsured in Washington and throughout the country. Lack of access to health services can delay diagnosis. And many of the poor who are at greatest risk of contracting TB have no convenient or reliable place to go for treatment.

Accessing care does not guarantee detection of TB infection, however. Patients were routinely treated in sanitariums, the last of which closed in Washington during the late 1960s. Since then, generations of health care providers rarely encountered a case. The public health system is working with providers to recognize the new face of the disease.

See <http://www.doh.wa.gov/cfh/tb>.



Public health agencies are stretched to their limits trying to keep older problems at bay and, at the same time, prepare for emerging threats. Over the past year, local and state public health workers have devoted time and special expertise to develop detailed plans to respond to SARS, West Nile Virus, bioterrorism, and avian flu. They did not happen in our state—but any of them *could* happen, at just about any time, and

the public health community must be ready to respond quickly to reduce the amount of disease and the number of deaths that would result.

### PHIP: vision to action

The PHIP is a consortium of the state Department of Health, the State Board of Health, the

## Promoting Tested Weapons Against Chronic Disease

Public health programs may not have eliminated the threat of infectious diseases, but they have removed them as leading causes of death. Today, more Americans die from chronic diseases such as heart disease, cancer, and stroke—and public health systems are eager to identify the most effective population-based approaches to reducing the rates of premature deaths associated with them.

Washington is the only state to receive two “Steps to a Healthier US” grants, as part of a federal initiative to identify strategies to prevent chronic disease—in some cases, right at the neighborhood level. The grants, which the U.S. Centers for Disease Control and Prevention awarded separately to the state Department of Health and Public Health—Seattle & King County, implement integrated, scientifically based strategies to drive down rates of obesity, diabetes, and asthma as well as their complications. This work has engaged hundreds of community partners, including schools, work sites, and health care providers.

The state grant will focus more than \$16 million in federal funds over five years in four communities: the contiguous area of Chelan, Douglas, and Okanogan counties; the Confederated Colville Tribes; Thurston County; and Clark County. Working with schools, work sites, health care settings, and the communities-at-large, the Steps program seeks to identify and implement sustainable interventions that improve access to healthy foods and opportunities for physical activity and reduce exposure to tobacco smoke and other asthma triggers. Entire communities—from children eating school lunches to local political leadership—are brought into these efforts. “We hope to see some real behavioral change,” explains state Steps Manager Lauren Jenks, “not just among community members but among policy makers, too.”

The local grant supports interventions in South Seattle and South King County, including programs to encourage students to become more physically active by biking to school and training community health workers to help families remove asthma triggers from the home.



Washington State Association of Local Public Health Officials (WSALPHO), the University of Washington School of Public Health and Community Medicine, and the Washington Health Foundation. Each partner is essential to strengthening the performance of Washington’s public health system and positioning it to address emerging issues effectively.

The future vision that guides this work (see inside cover) is complemented by a specific workplan that addresses seven broad goals. Each goal is supported by an active committee of professionals drawn from many fields. The members represent a wide spectrum of public health agencies: large and small, east and

west, practice and academic communities. Bringing talented people to the table on a statewide basis, the PHIP has become a conduit for innovation, for exchanging ideas, and for making commitments for action. The partnership has become an expected way of doing business in public health. It is collaborative, inclusive, and creative.

The work of each committee is carried out over two years and is summarized in this report, the *Public Health Improvement Plan*. The purpose of each committee is stated briefly below. Their recent accomplishments, and their complementary goals and written objectives for 2005-07, are shown on pages 12 and 13-14.



#### PHIP Committees:

- Use science-based strategies to signal important public health issues and trends (*Key Health Indicators Committee*).
- Make both state and local public health agencies accountable for meeting established performance measures (*Standards Committee*).
- Identify and describe stable, sufficient, and equitable funding needed to carry out public health services (*Finance Committee*).
- Link information systems and provide efficient tools for sharing information (*Information Technology Committee*).
- Maintain a well-trained workforce that has timely access to professional development (*Workforce Development Committee*).
- Explore community actions that promote health care access (*Access to Critical Health Services Committee*).
- Foster greater public understanding and involvement in achieving public health goals (*Communications Committee*).

Washington's public health officials believe that we can create a healthier future, where commu-

nities as a whole, and the families and individuals within them, are as healthy as they can be. This means more than an absence of illness—it means a robust level of well-being and a good quality of life for all.

The work of the PHIP helps us all pull together on efforts that will improve public health practice in every community. Using a Report Card, applying performance measures, and sponsoring workforce development are all ways to strengthen the network of agencies dedicated to better health.

In addition, active work is underway to translate public health ideals into everyday living. Programs such as “Steps to a Healthier US” (see box, page 10) can lead us to a healthier future. We have great opportunities ahead in the area of combating chronic disease, but we will make those gains only through concerted effort and a strong public health system.

Washington's public health system is poised to accomplish its goals. The ability to do so, however, will depend on resources needed to keep the public health system stable and well-prepared in every community.

#### Influencing the Nation

The Institute of Medicine has published two sentinel reports on the status of public health in the United States, in 1988 and in 2002. In both volumes, national leaders point out the serious risks of allowing our public health system to erode. The work plan of the Public Health Improvement Partnership responds to many of the recommendations and warnings of these reports, demonstrating for others what actions can reduce those risks.

Washington's Public Health Improvement Partnership is highly regarded by public health professionals throughout the country, and many of the specific projects outlined have been adapted for use elsewhere. Examples include our Report Card, standards, workforce study, and communications work. (For more information see <http://www.iom.edu/Object.File/Master/4/165/o.pdf>.)

# CHARTING OUR PROGRESS

The Public Health Improvement Partnership carries out its work according to a specific work plan. Checked items have been completed or are nearly complete by December 2004. Remaining items will be worked on during January through June 2005.

## Committee/Objective or Project

### Key Health Indicators Committee

- ✓ Maintain Report Card with data and grading.
- ✓ Develop Key Health Indicators Action Guide for the web.
- ☐ Improve data systems and use of systems for the Report Card.

### Standards Committee

- ✓ Implement measurement schedule; prepare for measurement.
- ✓ Test Administrative Capacities.
- ☐ Set system-wide priorities for future work and training.

### Finance Committee

- ✓ Study the cost of achieving the standards.
- ✓ Develop funding allocation principles and communications.
- ☐ Publish a white paper on public health funding.

### Information Technology Committee

- ✓ Maintain and share results of an IT survey.
- ✓ Continue VISTA development and use.
- ✓ Coordinate and prioritize IT work statewide.
- ☐ Develop IT minimum standards for security, planning, and data.

### Workforce Development Committee

- ✓ Enumerate the public health workforce.
- ✓ Acquire a Learning Management System.
- ✓ Develop a regional learning network.
- ✓ Maintain leadership development.
- ☐ Develop training based on standards findings.

### Access to Critical Health Services Committee

- ✓ Establish a committee on access from a public health viewpoint.
- ✓ Gather information on local efforts to expand access.
- ☐ Promote exemplary practices on access and seek support.

### Communications Committee

- ✓ Prepare materials and trainings for the public health Identity Campaign.
- ☐ Conduct a statewide education campaign.
- ☐ Conduct a mid-course evaluation of campaign materials.



# SUMMARY OF PHIP RECOMMENDATIONS FOR 2005-07

## Key Health Indicators

1. Adopt the Report Card.
2. Publish the Report Card every two years in a hard copy summary and web-based format, with links to additional information and interventions.
3. Commit resources to develop and implement a process to set targets.

## Public Health Standards

1. Adopt and apply the revised administrative standards as part of the *Standards for Public Health in Washington State*.
2. Analyze the 2005 results of the system-wide measurement of the *Standards for Public Health in Washington State* in conjunction with program requirements to identify or reinforce priorities for system-wide improvements.
3. Identify and test methods to incorporate the use of the standards throughout the work of public health as described in the legislation that requires the PHIP and development of the standards (see Appendix 7).
4. Adopt a contract monitoring system that uses the standards as a framework.

## Financing Public Health

1. Increase public health funding by \$400 million to close the funding gaps identified in the Finance Committee's cost model.
2. Expand the Finance Committee to include broader representation by state and local stakeholders to help identify opportunities to articulate the importance of fully funding our public health system, to explore viable state funding options, and to get this information to decision-makers.

3. Implement the work of the Funding Allocations Subcommittee to make certain that allocation formulas are clear and all funding for programs is easily tracked on a website.

## Information Technology

1. Develop a shared administrative structure for maintaining and enhancing evolving applications and development of a cost-sharing model for all public health IT systems in Washington.
2. Identify top-priority areas where better use of technology could improve public health practice.
3. Evaluate and recommend standards for hardware, software, servers, security, distance learning, and data collection and transfer.
4. Leverage financial investments in technology most effectively.
5. Review and evaluate applications to identify opportunities for efficiencies.
6. Implement on-going training into IT planning.

## Workforce Development

1. Implement recruitment and retention efforts at the agency and system level.
2. Identify and develop a new generation of managers and leaders to maintain and improve the performance of public health agencies and the overall public health system.
3. Build on the success of the first *Everybody Counts* report.
4. Promote access for public health workers to training, technology, and tools needed to support learning.

5. Use system-level competencies as the framework for assessing learning needs, and evaluate learning strategies that incorporate return on investment.
6. Evaluate the usefulness of certification and credentialing and other incentives at various levels of the public health workforce.

### Access to Critical Health Services

1. Collect and analyze community success stories.
2. Communicate lessons learned.
3. Promote integration and availability of data across programs.
4. Look for additional resources to build on this work.
5. Develop long-term policy with respect to critical health services.

### Effective Communication

1. Conduct advanced workforce training to strengthen understanding of public health.
2. Adopt a set of communication strategies that will achieve broader understanding of public health goals.
3. Collect and tell public health “stories” that illustrate how public health affects everyone who lives in or visits Washington.
4. Conduct a statewide media event to increase public understanding.

# KEY HEALTH INDICATORS: INFORMATION THAT WORKS

## A common framework for health

How healthy are we? What makes us so? How can we improve and protect our health? And how can we protect ourselves from myriad threats to our well-being? All health policy addresses these questions, and the answers encompass no less than all of the systems—public and private—that affect our health status. Capturing the answers in a framework that policy makers can use has engaged the Key Health Indicators Committee for the past five years.

Why is it so important to have a common framework? By focusing on the key determinants of health, we can turn our attention and resources to the aspects of health protection and promotion that promise the greatest gains in well-being for everyone.

Most people think about “health” in a very limited way. They think of doctor visits or hospitals. Sometimes they think about how they feel or how easily they can move about in daily life. The Key Indicators Committee takes a deeper look at health, focusing on the “determinants of health” and measuring those that have the greatest impact on our health. The contribution of medical care is important, and it is essential when a person becomes ill. But other factors have a much greater impact on our overall health, including personal behaviors, such as smoking and physical activity and the social and physical environments in which we

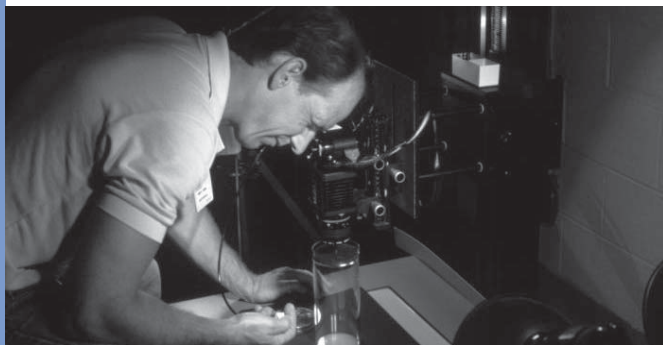
live. The graph on page 17 shows the relative weight of these factors.

## A Report Card to measure health

To track our health in Washington, the committee has developed a Report Card using the key determinants of health. Like all report cards, this one will carry grades—about our overall health, our environment, our social and economic health, our health care system, our communities, our families, and our individual behaviors. The focus will be on modifiable factors in each category. The committee has also added indicators to measure behavior among our youth, to learn more about our younger children’s readiness to learn, and to assess how our families are doing—because these are key components of health for children (see box, page 17).

The committee developed grading criteria that consider how well Washington is doing compared with the United States as a whole, whether an indicator is improving or worsening over time, and whether significant disparities exist among racial or ethnic groups.

The Report Card is intended to inform and stimulate state and community discussion, as well as policy development and action, by providing solid information that will lead to better-targeted actions, and ultimately, better health outcomes. It is intended to focus strategic investments in health throughout the



*To track our health in Washington, the committee has developed a Report Card using the key determinants of health.*

## What Are Health Disparities?

And why are they important to track?

Healthy People 2010, national objectives that set the prevention agenda for the United States, identified eliminating health disparities in the United States as one of its primary goals. This stems from a basic value: all people deserve the same opportunity to experience good health and quality of life (<http://www.healthypeople.gov/>).

A disparity in health occurs when one group of individuals experiences significantly greater—or worse—health than another group. Very often, health disparities exist among racial and ethnic groups. They may be the result of unequal access to medical care, or differences in income or education, or other factors. Identifying disparities is a first step toward understanding exactly which disparities exist, what contributes to them, and what can be done to eliminate them.

In developing Washington's Report Card on Health, we have put special emphasis on measuring disparities among racial and ethnic groups. This is a difficult task, and it requires analyses of many types of data, in varied formats (see Appendix 3). With a goal toward eliminating disparities, this information will help us focus resources on public health efforts that help “close the gap.”

state. Good decisions begin with good information.

The Report Card is designed to be simple and direct. To present more detailed information, the Department of Health will present the Report Card on a website beginning in 2005. The site will present the information that supports each grade, providing communities with meaningful data to inform community discussion and action in six broad areas:

- How healthy are we overall?
- How safe and supportive are our surroundings?
- How safe and supportive are our communities?
- How supportive is our health care system?
- How safe and supportive are our families?
- How healthy are our behaviors?

To maintain the Report Card, state epidemiologists will conduct ongoing data collection for the 52 indicators of health status (see Appendix 2 for the list). The Key Health Indicators Committee will assign grades every two years based on established grading components: comparisons, trends, and health disparities. The committee also intends to add one more component that will evaluate how well we are doing in meeting our goals. This will require the develop-

ment of Washington State targets for each of the indicators.

Among the challenges the committee has encountered so far is the lack of county-level data, which are needed if the Report Card is to be used throughout the state. The committee is considering presenting regional or multi-county data for some of the sub-indicators. Meanwhile, the committee has added questions to the Behavioral Risk Factor Surveillance System (BRFSS) survey to provide county-level data on unmet health care needs for adults and children.

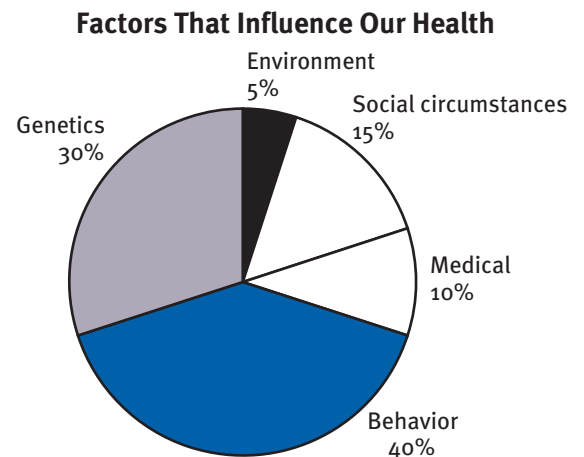
Availability of data remains a challenge for the committee, particularly in such areas as the safety of water systems and air quality. For example, at this time, the state is measuring the quality of only the large, “Group A” water systems, which means that the quality of the “Group B” systems, which serve 15 or fewer households, is not included in the data mix.

## Making evidenced-based investments in health

The committee recognizes that grades will not improve without interventions. In the future, it will provide links on the Report Card website to interventions for improving health outcomes.

There is much we can do individually and collectively to improve our health. Identifying best practice interventions that have been proven to be effective will assist state and local organizations in finding an approach that is right for their population. The on-line format will make it easy to refine and update the information. But as with much of the indicators work, the committee is learning what isn't available—including interventions for all the areas tracked by our health indicators.

It will take time to collect the data called for in our Report Card and to develop ways to make it easily accessible to people who must make decisions about health policy, expenditures, and programs. While the concept sounds simple, it has not been done before. As the Report Card is finalized, communities will be able, systematically, to use science-based, timely information about their own health, and they will be able to link it to the best available



Source: Health Affairs

information about what really works to keep them healthy. For more information on definitions and data sources for the Report Card, see <http://www.doh.wa.gov/phil/PHIP2004/ReferenceLinks.htm>.

## Report Card Sample

This is a short sample page from the PHIP Report Card. The full Report Card will be published separately and can be viewed at <http://www.doh.wa.gov/phil/indicators/draftreportcard.htm>.

### 1. How Healthy Are We Overall?

Category	Indicators	Compared to U.S.	Trend	Disparities	Final
How good is our general physical and mental health?	Expected years of healthy life at age 20	A	C	C	B
	Percent of adults who report 14 or more days of poor mental health in the past month	B	C	C	C
General Health Grade	Although Washington compares favorably to the U.S. on healthy life expectancy and mental health, we have not seen improvement since 1993 and there are moderate levels of disparities.				C
Are we a healthy weight?	Percent of adults who are obese	B	F	C	C
	Percent of 10th graders who are overweight	B	N/A	C	C
Overall Obesity Grade	Washington has relatively fewer obese adults and overweight 10th graders compared to the U.S. Nonetheless, in 2003 about 20% of adults reported heights and weights indicating obesity. About 10% of 10th graders were overweight in 2002. Washington's rates are moving in the wrong direction and we have moderate levels of disparities.				C

## Recommendations for 2005-07

### 1. Adopt the Report Card.

Developing a Report Card is no easy task. This one is the result of thoughtful collaboration by public health professionals throughout Washington. It has had considerable scrutiny and is drawn from the best available science. It focuses our attention on the underlying *determinants* of health—a focus that provides the best opportunity to improve health over time. This Report Card should be adopted and used by policy makers in many venues.

### 2. Publish the Report Card every two years in a hard copy summary and web-based format, with links to additional information and interventions.

Maintaining the Report Card should be a core activity of the public health system.

By making information about actual health trends readily available, we will have the knowledge needed to direct resources toward greatest needs and toward health interventions that show the greatest success. This will require funding for ongoing collection, analysis, and dissemination.

### 3. Commit resources to develop and implement a process to set targets.

Setting realistic numerical targets for health indicators, based on the best available science, will let us measure progress over time. Numerical measures will provide a clear picture of whether we are meeting our goals. Setting targets is a significant undertaking and will require a great deal of time and analysis on the part of people who contribute to this effort.



# PUBLIC HEALTH STANDARDS: STEPS TO IMPROVE HEALTH

The Standards Committee is composed of people who work in all aspects of public health—from clinical services to policy. They come from all areas of the state and represent public health practice at both the state and local level.

When the Standards Committee in 1999 began its work to develop a performance measurement system for Washington’s public health system, it could not know that the next five years would bring a series of challenges that would render the system increasingly fragile—and the standards even more valuable. The standards have identified system values—what is most important in public health—and directed quality improvement efforts during an onslaught of insufficient funding and new threats that have characterized the years since they were first published in 2001. The standards can be viewed at <http://www.doh.wa.gov/Standards>.

The standards set a level of expectation for the state’s public health system, both as a whole and as a network of individual state and local agencies. They are structured to follow the core public health functions as defined by the federal Institute of Medicine and the 10 essential services defined by the National Public Health Steering Committee (see Appendix 4 for a “crosswalk” of these guidelines). The standards address five general topic areas:

- Understanding key health issues
- Protecting people from disease
- Assuring a safe and healthy environment
- Promoting healthy living, and
- Helping people get the services they need.

The standards are not a statement of *new* work. Instead, they both describe work that is occurring and set expectations for the quality of that work. Until now, “public health” was viewed as a collection of individual, specialty programs, each with a separate means of support. These are sometimes referred to as “silos” in an organization: isolated programs where efforts are not integrated. Funding often drives that mind-set, with the creation of dedicated or special program funds. Funding for basic public health services has been largely ignored and has eroded. Measuring public health performance against the standards accommodates current programs—because they each fit in one of the five areas. Measurement also points out weaknesses where capacity to deliver basic public health services is missing.

More than 300 public health professionals were trained on use of the standards and how to prepare for an evaluation. In 2002, the standards were used to conduct a baseline assessment, which revealed system strengths and weaknesses. Implementing the standards is a process that has involved collaboration through debate, development, training, testing, and refining expectations.



*The standards both describe work that is occurring and set expectations for the quality of that work.*

National leaders and public health professionals in many other states have learned from Washington's experience. Our standards and the collaborative process of development have been adapted by other states. This work is frequently cited as a model for intergovernmental collaboration and as an example of how to make publicly funded programs accountable (see box, below).

### A baseline study

In 2002, the state Department of Health and every local health jurisdiction participated in a baseline evaluation of the public health system to see how well the system performs against the standards. The results of the 2001 study can be viewed at <http://www.doh.wa.gov/hip/Standards>.

The baseline study findings revealed that even where the system performs relatively well, there is much work to do. For example, the area of "understanding health issues" is the work that health departments must do to know when significant health problems emerge and to help communities identify priorities for intervention. Performance was relatively strong compared to other areas of the standards. But state offices met the expectation about three-fourths of the time, and local offices, just over half the time. In general, the scores reflect a lack of basic capacity—particularly dedicated staff time and technical tools needed for health assessment. (The section on Key Health Indicators in this report, beginning on page 15, discusses some of the types of information needed.)

### Other States Are Measuring Public Health Performance

Some other states have developed performance measurement processes for public health. Many of them have used the work in Washington as a guide. By exchanging information and ideas, states are working together and with national partners to improve public health practice.

Washington's process places emphasis on mutual accountability and collaboration. Similarly, in Florida, state and local public health officials participate in a joint conference for each local department every three years. They compare progress on community health indicators and make mutual commitments about what each entity, state and local, can do to improve the health of people and to assure agency efficiency.

At right is a self-assessment model developed through the national Turning Point project for use by public health agencies. It shows how standards and measurement can be used to assure that every agency has the necessary skills, accountability, and communications capacity to perform the work of protecting the public's health (see <http://www.turningpointprogram.org>).

Source: Turning Point Performance Management Collaborative



### Assessing their ‘Standard’ of Performance

In 2002, every public health agency in Washington—state and local—participated in a baseline assessment of how well they were meeting standards for their performance. The framework of the standards and the specific measurement data for each health jurisdiction and program is now used to improve public health practice. Following is what some of local health department managers had to say about the experience:

“Each year we complete an annual work plan. This year, we are revising our departmental report from the current program-based format to a standards-based format. The plan will have five sections and will describe work planned in each of the standard areas to help us meet community needs.”

“Many of the standards have been incorporated into our department’s planning and budgeting process. This process ranges from strategic directions through goals, objectives, and down to task level.”

“The standards baseline assessment identified the need for improved coordination between environmental health and infectious disease.... A regular debriefing and improved identification is now established between the two program areas.”

“The department identified key issues for each specific standards topic and developed work plans for each, as part of the 2004 budget development process. The board of health and county commissioners approved the plans and funding directed for each of these.”

Both the state and local agencies showed weaker results in the areas of “helping people get the services they need” and in environmental health measures, meeting the standards only half the time or less. In both areas, limited resources and dependence on fees or reimbursements result in programs that cannot attain the level of service and follow-through that is expected to meet the standards. For example, in the area of access to services, most health departments are able to refer an individual client to a needed service—if it exists locally. But the standards envision something more substantial: the ability systematically to know exactly what services are available, what services are lacking, and to work with communities to fill health service gaps, either within the community itself or from a neighboring one. This broader, community-based work is only rarely supported with funding.

### Putting the standards to work

One of the initial goals of the Standards Committee was to tie system performance, as

measured by the standards, to funding and state contracts as specified in RCW 43.70.580. This is still a goal of the Standards Committee and will be part of its work plan for the coming year. While some standards require more funding to implement them fully, others simply require improved documentation and focus on thoughtful planning and systematic approaches to public health problems.

In June 2004, the Standards Committee asked units within the Department of Health and most of the state’s local public health jurisdictions how they were using the standards. A strong majority of system managers—82%—reported that they had used them to guide performance improvement. Nearly three-fourths (74%) of the local agencies have used the standards to articulate their work to their local boards of health (see box, above).

Working with the Workforce Development Committee, the Standards Committee used the baseline assessment findings to direct strategies and training to improve the results for the next assessment. The committees are focusing

this work in three areas: community collaboration, creating and using a strategic plan, and program evaluation. Focused attention in these areas promises to improve performance system-wide across all five topic areas.

In addition, the Standards Committee has worked with the state's environmental health directors to refine the measures used in the area of "assuring a safe and healthy environment for people." With clearer measures, performance on those standards is expected to improve system-wide (see Appendix 5).

### Assuring administrative effectiveness

A major piece of the Standards Committee work during the past two years has been to develop administrative standards, which cover the topics of leadership and governance, human resources, fiscal management, and information technology. These were tested during 2004 in five counties and the Department of Health. The administrative standards clarify infrastructure and capacity issues, and while they are the last standards to be developed, they are critical to the work of public health professionals. The administrative standards will be used in conjunction with the other public health standards to assess whether a state or local entity has adequate systems in place. They will be field-tested in 2005 as part of the overall system assessment.

### "Costing" the standards

Over the past two years, the Standards Committee has worked with the Finance Committee to estimate the cost of implementing the standards fully across the state. For the local public health agencies, this has involved creating a

common list of system program areas and then estimating the cost of providing each service in a manner that would meet the standards statewide (see Appendix 8). For the state Department of Health, the process has involved identifying the current costs of meeting the standards to at least a 95% level. The findings from these two calculations will reveal the funding shortfall for meeting the standards across the system (see the chapter on the Finance Committee's work, page 25). That sum will express in stark terms what the standards process has already revealed: the system currently lacks the resources to meet the expected level of performance.

### Improving public health over time

In 2005, the evaluation process will be repeated to measure improvement in the intervening years and to see where focused attention is needed for future system improvement efforts. The criteria for determining whether a standard is met will require more than one example of performance for each measure, so more individual programs will be represented. In this way, the public health system as a whole is moving to a continuous quality improvement cycle.

While some improvements have already been made, the participating agencies face a host of new responsibilities since the 2002 baseline measurement, such as the threat of new communicable diseases and the responsibility to implement mandated programs to protect against bioterrorism. The next assessment will likely reveal how these pressures have helped or undermined public health system performance.



## Recommendations for 2005-07

1. Adopt and apply the revised administrative standards as part of the *Standards for Public Health in Washington State*.

The *Standards for Public Health in Washington State* address five topic areas important to public health protection and health promotion. In addition, every agency must have basic administrative services in place in order to be effective and reliable. These basic capacities are an important part of performance—and should be measured.

2. Analyze the 2005 results of the system-wide measurement of the *Standards for Public Health in Washington State* in conjunction with program requirements to identify or reinforce priorities for system-wide improvements.

Using the goal for the standards, “What every citizen has a right to expect,” the Steering Committee will identify one or more focus areas to concentrate efforts for improvement. Data from the 2005 evaluation will help to identify an area for improvement. The selection process could involve voting across state and local agencies so that the focus area represents the most important areas needing system-wide response.

3. Identify and test methods to incorporate the use of the standards throughout the work of public health as described in the legislation that requires the PHIP and development of the standards (see Appendix 7).

Performance and standards should be linked through careful restrictions. The resources needed to meet the standards are not available, and no agency should be penalized for that. Instead, the connection between funding and standards should focus on identifying gaps, outlining strategies for improvement, sharing best practices, participating fully in the measuring process, and timely reporting. Meeting the standards fully will require significantly greater resources.

4. Adopt a contract monitoring system that uses the standards as a framework.

The emphasis should be on the whole public health system and its purpose, not simply individual programs. The monitoring system should reflect the mutual accountability of state and local government to ensure that public health services are provided.

Performance measurement and quality improvement must be supported through changes to contract development, awarding, and monitoring; through funding and reporting requirements; and through training and recognition awards.



*Always working for a safer and healthier Washington*



# FINANCING PUBLIC HEALTH: INVESTMENT THAT WORKS FOR BETTER HEALTH SOLUTIONS

Financing is the Achilles Heel of our public health system—the enduring problem that makes it vulnerable. Public health programs rely on a complicated mix of federal, state and local funds. No single entity has overall responsibility to assure that the resources needed to protect the health of people are available or sufficient. There is no established level of funding and no stable revenue source to ensure that basic protection will remain in place when funding erodes at any level of government.

In 2002, the Finance Committee cited four key problems that must be overcome to assure an adequate level of protection in Washington:

- Public health is historically, persistently under-funded.
- Funding for core services is eroding, making the system very fragile.
- Investments vary widely from one county to the next, so protection is inconsistent.
- Categorical restrictions hamper efforts to respond to community needs.

No real progress has been made toward alleviating these problems during the past two years. The Finance Committee has accomplished some excellent work in this period, but the root causes for what ails public health lies beyond the committee's reach.

In 2004, the United Health Foundation published *America's Health: State Health Rankings*.

The report placed Washington at 44th—near the bottom—for spending on public health. When many health factors were combined, our overall health ranking dropped from 11th in 2003 to 15th in 2004. Regarding the drop, the report said: “This indicates that the state may not improve its relative healthiness in the near future unless the risk factors are more aggressively addressed.”

## Continued erosion of core services and growing disparities

Spending for core public health activities—for basic services—has experienced the most pressure. Historically, Washington's counties and their city partners paid for core public health services such as water protection, food safety, and communicable disease prevention and control. State and federal funding were added to provide special programs. But over time, the categorical restrictions that came with state and federal funds created lopsided situations where special services—but not basic services—would be funded. Today, as county funds shrink, our ability to maintain core public health protection has severely eroded.

Public health services across the state are funded in a piecemeal fashion, with every county setting its own spending levels. Declining local revenues have forced local government to make hard budget cuts every year. For example, in the past 20 years, county spending



*Public health managers today are quick to state that the system has reached a breaking point.*

on criminal justice programs has increased from 50% to 70% of county general fund outlays, leaving little money for public health or other local government services. After many years, this pattern leaves counties with uneven resources in disease control, environmental health protection, and health education.

Washington State has not established a basic level of funding for local public health protection. There is no minimum amount per citizen

from the state or local government, nor a broad commitment to systemic investments in protection. The inconsistency in public health funding across the state is reflected in the amount of local contributions for public health per person, which ranges from \$4.50 per year in some counties to \$71.69 per year in others. It also shows up in basic staffing levels: 15 of Washington's local public health jurisdictions have fewer than 6 employees per 10,000 population. The range is from 1.8 to 29.

### A Successful Public Health Investment: Tobacco Prevention

Anyone who doubts that spending on public health programs can save both lives and money should look at Washington's progress in battling the nation's No. 1 cause of preventable death: tobacco.

Since expansion of the state's Tobacco Prevention and Control Program in 2000, financed by resources from the national tobacco settlement and the state excise tax on cigarettes, the number of smokers in Washington has dropped by 12%—115,000 fewer people who suffer from the health, behavioral, and economic consequences of tobacco use. Washington's adult smoking rate of 19.7% is among the "lowest 10" of all the states and below the national median of 22%.

Since inception of the expanded program, Washington has invested about \$90 million in tobacco prevention and control. This work has saved an estimated 38,000 lives from early tobacco-related deaths as well as \$1.4 billion in future medical costs.

The program's four categories of activities—preventing youth from beginning to use tobacco, helping youth and adults quit, reducing exposure to secondhand smoke, and reducing tobacco use in high-risk groups—engages thousands of people throughout the state every day. More than 44,000 Washington residents have already called the state's "Tobacco Quit Line" (800-877-270-STOP). A media campaign warns children and youth, ages 8-18 years, of the dangers of smoking and exposure to secondhand smoke—on television and radio, in print, in convenience stores, and in recreation centers.

Considerable work in tobacco prevention is left to do. With nearly 1 in 5 of all adults still smoking, the state can expect tobacco-related diseases to kill 8,000 people every year. About 20,000 children and youth in Washington will begin smoking this year. Ten percent of pregnant women in the state still smoke during their last trimester. And Washington's \$29 million annual investment in tobacco prevention is up against the \$300 million the tobacco industry spends in the state every year to encourage people to smoke.



## Prevention by the Numbers

It is impossible to put a dollar value on “health.” But it is possible to calculate the economic impact of preventable health problems. Healthy People 2010, the set of national objectives that represent the U.S. “prevention agenda,” includes an analysis of the how public health prevention activities save costs associated with unhealthy environments and behaviors. Among the costs that could be mitigated with prevention:

- 50,000 premature deaths and \$40-50 billion in annual medical costs resulting from human exposure to outdoor air pollutants from all sources
- \$3 billion each year in hospitalizations and from \$20-40 billion a year in lost productivity associated with illness from microorganisms in food
- \$55,000 to \$155,000 or more per person in lifetime costs associated with HIV
- As much as \$6,300 for first-year medical costs for every case of Lyme disease that isn’t caught in the early stage
- 55,000 cases, 11,000 hospitalizations, 120 deaths, and \$100 million in direct medical costs associated with a measles resurgence in the United States during 1989-91
- \$224 billion in annual costs related to preventable injuries
- \$6,200 in average hospital costs for each low-birthweight birth, compared to \$1,900 for a normal, healthy delivery
- \$200 billion a year for medical expenses and lost productivity associated with poor nutrition
- \$6 billion in medical expenditures and lost productivity related to asthma
- 430,000 deaths a year and \$50 billion in direct medical costs associated with tobacco use

## Health impacts of declining resources

Washington’s public health workers have shouldered the burden in lean times and shown that they can do more with less. But the size of our public health workforce has remained basically static during the past 10 years, while the workload has been growing. Public health managers today are quick to state that the system has reached a breaking point. Unreasonable workloads and staff burn-out are direct outcomes. The health impacts will come later, as a faltering system must contend with complex problems. These include the re-emergence of resistant strains of diseases such as tuberculosis, syphilis, and staph; the emergence of global infections such as SARS; the specter of catastrophic events such as mad cow disease, and the additional responsibility of becoming one of the first responders to acts of bioterrorism.

The cost of lost opportunities is even greater, though difficult to see. With the workforce pared down and constantly responding to urgent situations, investments in prevention get pushed aside, despite their promising poten-

tial. Washington’s special efforts in tobacco have reaped huge rewards (see box, previous page). We could lessen the toll of later, high medical care costs if similar investments were made in early childhood screening, physical activity, nutrition, environmental health protection, and early intervention for mental health and substance abuse.

Today, less than 1% of the nation’s \$1.5 trillion health tab is directed toward public health measures, despite the fact that they are proven to be effective and offer greater return on investment than medical care (see box, above). What is needed is a formal national and statewide “prevention agenda” that demands increased prevention investments for every public dollar spent on medical care.

## Estimating costs of adequate public health protection

What should we be spending on public health in Washington? With publication of the *Standards for Public Health in Washington State* in 2001, the Finance Committee and the Standards

## Spending Too Much on Health Care—but Not Enough on *Health*?

U.S. spending on health has reached \$1.5 trillion annually. But the way we spend this money does not logically follow the factors that we know determine our health.

For example, a Priorities of Government group considering health expenditures in Washington State has adopted a set of recommended priority strategies that is based on the determinants of health (see page 17). But it saw major discrepancies between these priorities and where state health dollars actually go. Some examples:

- *Our behavior* accounts for about 40% of how healthy we are, but state spending to support healthy behavior is only about 2.5% of the overall health budget.
- *Our surroundings*—environment and social circumstances—account for about 20% of our health, but we spend about 2.8% of our health budget in these areas.
- *Medical care* contributes only about 10% to our overall health, but it consumes about 95% of Washington’s state health budget.

Medical care is essential, and seeing that all who need it have access is a core function of public health. But medical costs are rising far faster than either government, payers, or consumers can afford. If we invested more in preventive measures, we might be able to reduce spending on health care to affordable levels.

Source: Projected expenditures, 2005-07 biennial budget, based on Washington State Department of Health Priorities of Government Health Committee

Committee were able to join forces to determine the cost of providing the services that all Washington residents have a right to expect from their public health system. In effect, the two committees have worked to “cost” the standards at about a 95 percent performance level—a level the committee members considered to be realistic.

The joint committee created three “cost models” that capture the specific responsibilities of state, local, and metropolitan public health jurisdictions. Each of these models is based on clearly defined assumptions. To guide this work, the Finance Committee developed a list of essential public health activities—those necessary to the public’s health and that should be provided by public health agencies if there is no one else in the community to do it—and organized the services according to the standards framework (see Appendix 6).

To meet the standards for public health statewide, the committee estimates it would take additional investments of \$400 million per year—with most of that, \$385 million, spent at

the local level. While this amount is roughly double what we now spend at the local level, it remains only a few cents on the dollar for what is spent every day for medical care services *after* people have become ill with an infectious disease, a chronic condition, or a mental illness.

Based on reports from the U.S. Department of Health and Human Services and reports on public health spending in Washington State:

- Medical care spending is roughly \$4,370 per capita, per year.
- Public health spending is roughly \$98 per capita, per year.
- If fully funded to meet the standards, public health spending would be \$163 per capita, per year.

The cost estimate work creates a rational framework for funding public health, but alone, it does not achieve the goal of a “stable and sufficient” financing system for public health that the first PHIP called for in 1994. Meeting that goal will require a collective effort among

state and local elected officials, public health agencies, and their community partners to provide needed resources and to identify new funding sources. In recognition of this necessary next step, the Finance Committee will draft a white paper on public health financing that describes our current system's strengths and weaknesses and encourages policy makers to explore potential new funding sources.

### **Improving the way we manage funding**

Although the Finance Committee cannot change national investment strategy, it has elected to work on some issues that will improve quality in our state's system. The committee has identi-

fied ways to spend the system's limited dollars more efficiently by examining the complex flow of categorical funds from the federal government to the state and on to local public health jurisdictions. It has developed templates that will provide a standardized process for allocating funds and established criteria for reviewing and updating funding allocation formulas. The committee also drafted principles for funding allocations, so that available funds will be distributed in an equitable and predictable manner (see Appendix 9). This work will help state and local health officials make reasonable decisions about how best to allocate limited resources.



## Recommendations for 2005-07

1. Increase public health funding by \$400 million to close the funding gaps identified in the Finance Committee's cost model.

Stable and sufficient sources of funding are essential to maintaining a sound public health system. All residents need and expect a predictable level of public health protection.

2. Expand the Finance Committee to include broader representation by state and local stakeholders, to help identify opportunities to articulate the importance of fully funding our public health system, to explore viable state funding options, and to get this information to decision-makers.

Active involvement by concerned citizens and policy makers is critical to solving the chronic funding instability that plagues public health. The Steering Committee will

look to a specially organized group to study alternative financing strategies and seek solutions that will work, statewide.

3. Implement the work of the Funding Allocations Subcommittee to make certain that allocation formulas are clear and all funding for programs is easily tracked on a website.

Given scarce resources, every dollar in public health needs to be used efficiently. The Finance Committee will continue to work to improve funding practices to achieve a common understanding of allocation principles and how they are used. Additional work will be pursued on statewide program evaluation and on clarifying data needs so that required program reports are as simple as possible, yet support accountability measures, program evaluation, and where feasible, needed research.

# INFORMATION TECHNOLOGY: RELIABLE INFORMATION FOR BETTER HEALTH

The Information Technology Committee ensures that Washington's public health professionals have access to information and technology when and where they need it—from the simple extension of e-mail systems onto handheld devices to installation of complex security functions so that data are protected. The goal is to employ appropriate and effective technology, in the background, to make the work of assuring the public's health easier, more efficient, and more effective.

## Rapid changes and growing expectations for “e-government”

People expect government agencies to adopt technology-based ways of doing business when it translates to faster and better service. For example, public health agencies used to rely on a paper-based system for birth certificates, making obtaining birth records a somewhat slow process. Today, birth certificates are issued from an electronic system that links hospitals, all local health jurisdictions, and the state vital records office. Obtaining records is quick and can be done from any county in the state, regardless of where the original certificate was issued. Next, death certificates will become part of an electronic system. In both cases, developing these systems takes time, and a significant initial investment must be made to acquire new technology. But the updated systems are more efficient and provide tools for long-term cost savings.

Change has always been a part of the information technology (IT) field, but the rate at which this change occurs has increased dramatically in recent years, and public health agencies are challenged to keep pace. Most phone systems are complex computers, and most workers use a personal computer during their workday. Many factors combine to put pressure on public health to adopt new technology including new federal laws on medical record handling, changes in computer operating systems, and the adoption of new technology by partners.

Across all service areas, there is a need to adopt new technology: keeping track of data for client records or evaluation, using handheld computers in the field to save time transferring information later, adopting new analytical tools to support decision-making. All of this translates to a new demand within public health; IT tools have become a critical part of our infrastructure and will require resources as we adapt to the new “electronic” world.

## The need for system-wide coordination

Most local health jurisdictions rely on county governments to provide their basic IT infrastructure, and each county government has its own process for procuring equipment, software, and support. Yet there is increasing need for state and local public health offices to share information quickly, and reliable interconnectivity between these systems is required. As the



*As more applications are developed, it will be increasingly important to have a central forum for planning and coordinating IT work.*

public health system evolves, it will be important to move from “home grown” systems that evolved without common standards to a more sophisticated approach that will allow integration of information management within large systems.

The Information Technology Committee has provided an initial forum to coordinate across disparate IT environments, so that public health agencies can work as members of a shared system. The committee approaches IT planning for public health in terms of designing interconnecting pieces that are based on “common architecture” or design standards. It has helped set priorities among many emerging information-technology applications.

The committee is also working with a growing circle of partners who are essential to public health, including clinical laboratories, hospitals, and funeral homes. Some of the applications under development will connect these entities to public health agencies, on a continuous basis, 24 hours a day, seven days a week.

As more applications are developed, it will be increasingly important to have a central forum for planning and coordinating IT work. The Information Technology Committee, or an entity established as an outgrowth of this effort, can play a crucial role in guiding coordination in areas such as funding, maintenance, and oversight, as well as such routine operational tasks as authorizing access, maintaining security, and training individuals in the use of applications. The impact of this work will be to reduce duplication, assure “interconnectivity” so health departments can share information as needed, and reduce expenditures over time, perhaps through joint purchasing power.

### New roles emerge, along with technology

As information technology becomes a prominent part of public health practice, it has a direct effect on the workforce. Some jobs are performed differently with technology, so new skills are needed. Sometimes, whole new roles emerge as a result of adopting new technology. For example, making training accessible statewide requires someone with specialized skills

to manage distance learning technology such as satellite transmission, on-line courses, and web-conferencing. With many aspects of public health practice adopting technology tools, new worker roles are emerging to handle a broad array of IT needs, from basic computer support to training in the use of various applications.

Technology is also changing the way agencies relate to one another. The committee is considering the essential roles and activities that must be performed in every public health agency so that information is secure—yet can flow easily. This requires agreements about how data will be handled, who will authorize access to data, where data will reside, and how data will be kept up-to-date (see Appendix 10).

### Information systems that are improving public health today

While technology comes with challenges, it also brings tremendous benefits that can improve the quality of public health services. Washington’s innovative public health workforce has some very valuable applications developed or in development. Some examples are detailed below.

- The **Public Health Issue Management System (PHIMS)**, a secure, web-based application for local health jurisdictions and Department of Health staff to use to investigate and report communicable disease, is in production in several counties. Local health jurisdictions will use the new PHIMS to investigate and report disease occurrence to the state Department of Health, which can send the information on to the federal public health agency, the U.S. Centers for Disease Control and Prevention (CDC). PHIMS will bring faster disease outbreak investigation and quicker treatment, which should result in reduced spread of disease in the community.

PHIMS will make it faster and easier to maintain accurate records during a disease event, and comparable information can be shared across counties when needed. It can summarize and

provide data for charts showing the trend in a disease outbreak. Without PHIMS, every jurisdiction has to create and maintain its own records and carry out its own analysis—all of which can be very time-consuming.

- The **Washington Secure Electronic Communication and Urgent Response System (WaSECURES)** is a secure web-based tool providing urgent communication for public health emergency response partners. Many public health partners now send such messages via e-mail listservs, with no way to verify whether the intended recipients have received them. In the WaSECURES application, an emergency notification is typed into the system and converted to audible voice. The notification can then be sent via e-mail, pager, or phone.

WaSECURES will be very important if we have a natural disaster, terrorism event, or other catastrophic health event where the entire system must mobilize quickly. When danger is high and time is short, public health expertise will be needed quickly. Through WaSECURES, Washington's public health leaders will be able to respond after hours as well as during the regular work week.

- Speed is often very important in responding to a public health concern, whether to rule out a problem such as rabies or SARS—or to confirm a problem and initiate appropriate action. The **Public Health Reporting of Electronic Data (PHRED)** system is a secure, web-based application that hospitals and laboratories will use to transmit laboratory reports electronically. The system will pass these laboratory results to the appropriate local or state agencies. This reporting includes both infectious and non-infectious conditions. The results of using PHRED will mean some people can start treatment sooner, reducing disease in the community, and public health officials will have added ability to track disease patterns.

- **VISTA** is a standardized tool that helps collect, analyze, interpret, and share information for community health assessment. This web-based, menu-driven software package—now used across the state's public health system—allows users with diverse computer skills to access and analyze population-based health data. New features include integration of 2000 Census data and sub-county population estimates (see <http://www.doh.wa.gov/OS/Vista/HOMEPAGE.HTM>).
- **“EDITH”** is an Electronic Data Transfer Hub that provides a secure, reliable, Internet-based system for the electronic interchange of public health information. Initially, it will focus on handling information about laboratory-notifiable conditions, as defined in WAC 246-101.
- **The Electronic Death Registration System (EDRS)** is a secure, web-based application that will enable the professionals participating in death registration to file death records with local and state registrars electronically. It will allow decedent demographics and cause-of-death information to be registered electronically by multiple participants.
- **EpiQMS** is a tool for analysis of health data that may include a geographic information system (GIS) function.
- **Epi-X** is a secure, web-based communication system provided by the CDC to state epidemiologists and various other public health officials.
- **The Pre-Event Vaccination System (PVS)** is a web-based system that supports the secure exchange of data about those being vaccinated against smallpox. The states and CDC will continue to use this information to ascertain progress in preparedness activities, to assist in the monitoring of adverse events, and to track personnel who are protected by vaccination and able to participate in smallpox response efforts.

## Recommendations for 2005-07

1. Develop a shared administrative structure for maintaining and enhancing evolving applications and development of a cost-sharing model for all public health IT systems in Washington.

Work has progressed on IT systems that will serve both governmental and non-governmental agencies at both the state and local level. A shared administrative structure is needed for the ongoing maintenance and improvement of these applications, as well as for considering cost-sharing models and a variety of funding sources.

2. Identify top-priority areas where better use of technology could improve public health practice.

Using prior analyses of business needs and new information, the committee should consider which programs and activities would benefit most from new technology applications. Some specific examples might be home visits or restaurant inspections or system-wide applications for documenting client services.

3. Evaluate and recommend standards for hardware, software, servers, security, distance learning, and data collection and transfer.

With the goal of seamless integration, a common look and feel, a common point of entry and security, the IT system standards are essential to assure that the public

health system remains connected and able to share information quickly and confidentially. The committee should also explore the ideas of role-based standards: defining what is expected of a person based on job function as well as the roles and responsibilities of various agencies in the information chain.

4. Leverage financial investments in technology most effectively.

The committee and partners should explore ways to calculate the maximum benefit of the new technologies, including a cooperative model with shared resources and group purchases.

5. Review and evaluate applications to identify opportunities for efficiencies.

The committee should seek ways to improve the ability to analyze, aggregate, and use existing data by implementing standards, avoiding duplication, using common data elements and definitions, and developing interface applications where needed. It should also explore ways to develop a common look and feel for accessing a variety of data sets.

6. Implement on-going training into IT planning.

Computer applications will be effective only when accompanied by training. The committee should consider ways to develop and implement “informatics competencies” as well as an IT resource center.



# WORKFORCE DEVELOPMENT: A STATEWIDE NETWORK OF PUBLIC HEALTH PROFESSIONALS

For Washington's public health system to be "always working," it needs appropriately trained and skilled workers. And once on the job, these workers need ongoing support—job orientation, mentoring, and distance learning opportunities—to keep working effectively. Finding and keeping public health workers, and giving them the professional development they need, are the two parallel interests of the Workforce Development Committee.

Findings from the 2002 baseline measurement of the *Standards for Public Health in Washington State* underscored what many public health practitioners experience first hand: training and employee development are too often casualties of funding losses and workload demands. Training records were not routinely kept, training needs were cited in a broad range of specific and general topics, and there was a general lack of training about basic public health.

In the continually changing health fields, training is essential throughout a worker's career, and it has a direct impact on individual and agency performance.

## Getting to know the workforce

During 2003, we conducted our first-ever census of Washington's public health workforce, *Everybody Counts* (see next page). The report gave us a first detailed look at who works in public health, what educational backgrounds they brought to their jobs, how

long they have worked, and how long they expect to stay in public health. Significantly, more than 1 of every 6 of the state's most experienced public health employees—those who have worked for the system for two decades or more—expect to leave the public health field within five years. This finding shows why workforce planning, particularly in the areas of recruitment and retention of skilled workers, is a committee priority.

The multidisciplinary nature of public health and geographic dispersion of the workforce provides some formidable challenges to workforce development activities. Workforce development programs must address the needs of workers as diverse as veterinarians, midwives, nutritionists, and wastewater treatment systems inspectors. And learning opportunities must be available in rural towns as well as in large cities.

A full report about Washington's public health workforce can be viewed at <http://www.doh.wa.gov/hip/communications/tools/survey/everybodycounts/>.

Washington State provides leadership to the six-state Northwest Regional Workforce Development Network, which is coordinated by the UW Northwest Center for Public Health Practice. Through the network, leaders from throughout the Northwest collaborate on development of training needs assessments, training plans, and learning opportunities. In the coming year,



*Training and employee development are too often casualties of funding losses and workload demands.*

## Mapping the Workforce: Everybody Counts!

About 5,400 people work for Washington's governmental public health system—the state Department of Health and the 35 local public health jurisdictions. We now know about many of the characteristics of these workers, because we counted them in November 2003 in the state's first-ever census of our state's public health workforce, *Everybody Counts* (<http://www.doh.wa.gov/hip/communications/tools/survey/everybodycounts/>).

We now know several of the demographic characteristics of these workers:

- 74% are female
- 88% are white
- 40% are younger than 45 and 22% are 55 or older

We know about their educational backgrounds:

- 9% hold associate degrees.
- 38% have bachelor's degrees.
- 22% have earned master's degrees.
- 2% hold professional degrees.
- 2% hold doctoral degrees.

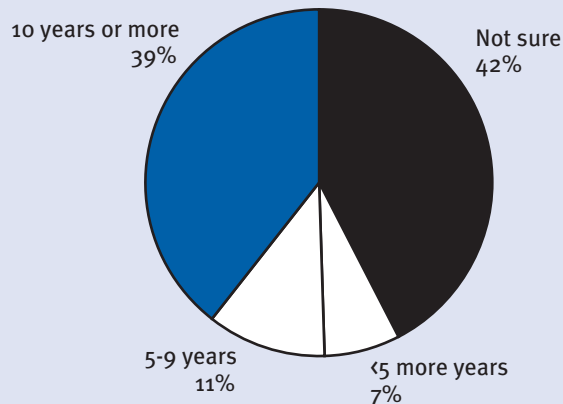
We know the fields in which Washington's public health workers are most likely to hold degrees:

- 16% in nursing
- 12% in business administration, public administration, policy, public affairs, and law
- 11% in chemistry and biology
- 8% in psychology, counseling, and social work

And we know something about current workers' plans for staying in the public health field, as shown in the chart above.

*Everybody Counts* is a first step to understanding Washington's public health workforce. The Workforce Development Committee has recommended conducting the census every 3-5 years and expanding its reach to include those who work as the system's non-governmental, community partners. The first count has already revealed important policy issues to guide workforce development activities. These include increasing worker diversity to reflect the composition of the population it serves, preparing for retirement transitions, and forecasting educational and training needs.

**Years Expected to Work in Public Health**



the network will be working both on examination of approaches to worker certification and development of mentoring programs.

### Developing managers and leaders

Market conditions present a considerable challenge to recruiting and keeping strong public health managers. Often, public health jurisdictions cannot pay the salaries needed to compete effectively with the private sector for

the most skilled managers. Finding new managers within the public health system would help address this challenge, but Washington lacks any formal or informal system for developing management skills among people with strong public health experience.

The Workforce Development Committee is studying a variety of learning strategies to develop public health managers and leaders. These include both formal education methods

as well as less traditional instructional venues such as short, web-based interactive modules and mentoring, peer consultation, and apprenticeship programs. To retain the most skilled workers, the committee is exploring ways to make compensation competitive with the private sector and to offer more versatile, rewarding, and challenging career tracks.

The Northwest Public Health Leadership Institute is an example of one promising strategy (<http://healthlinks.washington.edu/nwcphp/nwphli>). This is a partnership between the UW Northwest Center for Public Health Practice and the states of Alaska, Idaho, Montana, Oregon, and Washington that began in 2003. This year-long experience builds participants' collaborative leadership skills through on-site and distance learning opportunities. Participants are guided by practice-based faculty, including scholars from such diverse backgrounds as government public health, community health centers, community hospitals, community-based organizations, and social service and law enforcement agencies. Participants develop leadership skills while working on innovative

approaches to public health problems at the community level. Central to this work is the assumption that many sectors of the community must engage in the process of promoting health, so participants include leaders from politics, business, and the non-profit sectors as well as government public health agencies.

### Planning to meet workforce needs

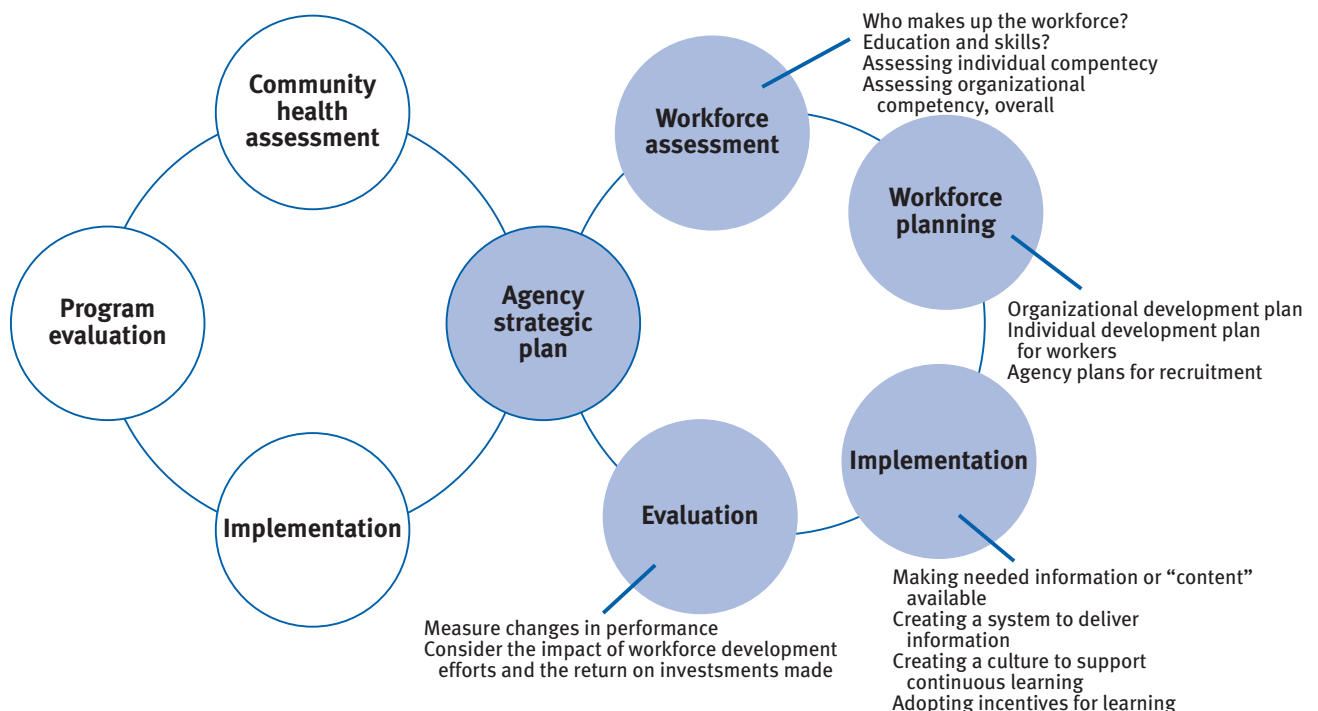
To meet the needs of the public health system, workforce development activities must support goals of both the public health system and individual agencies. *Standards for Public Health in Washington State* provide one way to approach this, by helping organize workforce development efforts toward areas where overall performance in the system needs to be strengthened.

Using the standards baseline findings, the Workforce Development Committee has begun to develop model training plans in three areas that have been selected as most important for the workforce, including:

## Linking Public Health Planning and Workforce Development

This is how a public health agency might approach its regular planning cycle.

Planning for workforce development is an important component of the planning cycle. The Workforce Development Committee pictures it like this:



- Increasing skills for community collaboration,
- Creating and using a strategic plan, and
- Conducting program evaluation.

For each area, the training plan will show the related standards and administrative capacities required in this area. Then, the model plan sets forth desired individual competencies and learning strategies (various ways to increase skills), and it names the types of worker for whom this is most important. Once fully developed, the training plans can be used by individuals seeking to improve their own performance and by administrators seeking to improve performance agency-wide (see <http://www.doh.wa.gov/phip/PHIP2004/ReferenceLinks.htm> for a sample of a draft training plan).

In selecting an approach to the training plan work, the Workforce Development Committee has placed emphasis on some key beliefs:

First, *performance improvement* is the goal—not “training.” Training, alone, does not always result in better skill or improved job performance. Instead, the committee has put its attention to a wide range of strategies that promise to result in improved performance among workers.

Second, expected *competencies* need to be defined and related to job function or employee role. To be a successful worker, and to assess your workforce as a manager, it is important to have a clear understanding of the skills and knowledge required for each job.

Third, *workforce planning* should be done as part of an agency’s strategic planning cycle. As agency planning focuses on future goals, it is imperative to have a formal way to assess and plan for the changing needs of workers. This relationship is shown on page 37.

## Competencies as a foundation

The 2002 PHIP included a general list of proposed public health competencies covering nine areas. These describe areas where public health workers need to have skills, such as communication, systems thinking, and leader-

ship (see Appendix 11). These competencies represent the general system-level knowledge and skills that are needed to achieve the *Standards for Public Health in Washington State*. The level of competency people actually need to do their jobs well varies by position or role, so the committee is currently detailing competencies for individual public health workers. In time, these can be used to evaluate individual training needs and target specific performance areas.

## New training tools and approaches

Historically, formal classroom training has been the most common method for delivering training to public health workers. But new technology has provided creative formats to make learning more accessible and more timely. Several new learning tools are now being used by Washington’s public health workers, including:

- **Learning management system:** During 2005, public health workers will be able to access training using a web-based system that will allow people to register for in-person and on-line courses and to maintain training records. In time, this system will be able to link training to specific competencies. The LMS is a tool to help manage different types of learning, to help individuals set training goals, and to assist with workforce planning (see box, page 39).
- **On-line orientation:** An expanded on-line orientation for new public health leaders offers additional learning resource materials based on specific public health roles (<http://www.doh.wa.gov/pho/default.htm>).
- **Web conferencing:** The Northwest Center for Public Health Practice has made this new resource available to the northwest states. This is a tool that uses both the internet and phone to make training accessible from the desk, without requiring travel. It provides critical learning and information on current issues to public health practitioners in diverse

## Tracking Skills and Readiness of the Public Health Workforce

Following are some of the ways that Washington's learning management system (LMS) will improve the delivery of training in ways that meet the diverse needs of our state's public health workers.

- By providing “just in time” training for handling emergencies and new or emerging disease and threats
- By tracking individuals, organizations, and system-wide education/training records
- By administering and managing educational programs at the local level
- By identifying organizational or individual competencies
- By identifying course competencies
- By performing assessments to identify organizational and individual learning gaps
- By delivering education/training
- By developing educational content
- By sharing best practices
- By providing the basis for mobilizing public health workers for events or emergencies
- By providing collaborative work tools

locations, across a six-state region. An example of one training series being delivered with this tool is *Hot Topics in Preparedness*, which are monthly, hour-long forums on such topics as preparing for SARS and a possible flu pandemic. These forums are archived so that they can be viewed and heard on-line at the most convenient time for individual workers (see <http://healthlinks.washington.edu/nwcphp/htip>).

- **A web-based information clearinghouse:** *AssessNow* is a web-based learning resource for public health staff working in community health assessment throughout Washington. It provides information, tools, resources, and a venue for dialog to improve the practice of assessment and the use of assessment data for public health decision-making. The first phase of *AssessNow* can be found at <http://www.doh.wa.gov/EHSPHL/AIA>. Key elements include: publications, data sources, and an assessment toolkit. The second phase of this work, to be

completed during 2005, will include password-protected templates, work samples, a technical assistance staff directory, and additional training materials on assessment methods.

- **Cross-discipline training:** Technology brings unique benefits, but traditional classroom education is still effective for many areas of learning, especially when the goal is to help different disciplines work together. For example, the training module *Forensic Epidemiology: Joint Training for Law Enforcement and Public Health Officials on Investigative Responses to Bioterrorism* engages law enforcement and public health officials in working through fact-based case scenarios involving biological weapons. The module was developed jointly by the U.S. Centers for Disease Control and Prevention and the federal Department of Justice. In Washington, this training module has used a “train-the-trainers” strategy to emphasize peer teaching and to create additional capacity to sustain the training over time.



## Recommendations for 2005-07

1. Pursue recruitment and retention efforts at the agency and system level.

Coordinated statewide recruitment strategies could include marketing the appeal of living and working in Washington State; recruiting workers from such underutilized venues as technical schools, student and professional organizations; and implementing creative loan repayment and tuition reimbursement incentives. Retention activities could include mentoring, promoting a learning culture in the field so workers will want to stay, exploring financial and non-financial incentives for continued learning and development, and exploring ways to extend the contributions of retirement-eligible workers.

2. Identify and develop a new generation of managers and leaders to maintain and improve the performance of public health agencies and the overall public health system.

As today's leaders move toward retirement, it is crucial to develop new ones ready to take the helm in public health. The six-state leadership institute begun in the past few years at the Northwest Center for Public Health Practice is an excellent start, but long-term strategies should be established to ensure that we are ready to face tomorrow's public health challenges.

3. Build on the success of the first *Everybody Counts* report.

Conduct this census every 3-5 years and expand it to include public health partners such as tribal public health agencies, community-based organizations, community health clinics, and other public health partners.

4. Promote access for public health workers to training, technology, and tools needed to support learning.

Workers need adequate access to the technology (i.e., web-connected computers, DVD players, telephones with headsets or speaker phones) through which learning is delivered.

5. Use system-level competencies as the framework for assessing learning needs and evaluate learning strategies that incorporate return on investment.

To support the mission of public health effectively, a system-wide perspective should be used in designing curriculum and in evaluating and measuring performance—for both individual public health workers and their agencies. Investments in training and performance improvement should be evaluated to show they yield desired results.

6. Evaluate the usefulness of certification and credentialing and other incentives at various levels of the public health workforce.

Credentialing may be one way to formalize the workforce development and planning that is needed throughout the field of public health. Careful assessment of the benefits and costs should be done.

# ACCESS TO CRITICAL HEALTH SERVICES: HELPING PEOPLE GET NEEDED SERVICES

Access to health services is a high-profile public policy issue at the local, state, and federal level. As health care costs continue to escalate, and a growing share of Washington residents lose private and public health care coverage, the state's public health system role in assuring access to critical health services—a core public health function and one of Washington's *Standards for Public Health*—becomes increasingly important.

But achieving this ambitious goal, even in the best of times, requires a series of steps and decisions to determine which services are truly essential, identify gaps in these services, and engage community partners in closing these gaps. Making substantial progress in these areas while local resources shrink and safety nets fray is all the more daunting. Innovative leadership, community mobilization, and regional and statewide collaborations are required to deal with a problem of this scope and magnitude.

The Washington State Board of Health (SBOH) took the first steps in addressing this public health standard by asking the question, “Access to what?” Its answer, published in 2001, was to define critical health services as “safe, evidence-based health care services that have a predictable benefit to the health status of the community at large.”

The SBOH then developed a Menu of Critical Health Services, which lists the health care

services and health conditions or risks for which appropriate services—screening, education and counseling, or interventions—should be available in every community. The menu addresses eight areas: general access; health risk behaviors; communicable and infectious diseases; pregnancy and maternal, infant, and child health and development; behavioral health and mental health services; cancer services; chronic conditions and disease management; and oral health.

Using an evidence-based methodology, the SBOH reached a clear determination that access to needed health services requires much more than personal medical care. Improvement of community health status requires a broad range of complementary health services that are often overlooked and unappreciated in the continuing debate over access to health services. The SBOH saw the broadening of this vision of what it takes to have a healthy community as a unique mission for the public health system in general and the PHIP access standard in particular (see <http://www.doh.wa.gov/phip/Access/default.htm>).

With the menu established, the SBOH turned to the task of measuring access to health services and identifying access gaps at the community level. Early on, it determined that reliable local data about access to the critical services simply do not exist.



*The State Board of Health reached a clear determination that access to needed health services requires much more than personal medical care.*

The Access Committee, joined by a new partner, the Washington Health Foundation, has embarked on several activities designed to improve health services access issues at the community level. The committee has begun to work closely with local health jurisdictions, provider groups, and other community partners to understand better the successful access projects that are underway throughout the state. The committee hopes that a systematic review of these success stories will identify innovative strategies, essential community partners, and the types of technical assistance that are needed to support local access projects among Washington's diverse communities.

Following are some of the efforts underway across the state to address access issues:

- The Washington Health Foundation's **Healthiest State in the Nation Campaign** builds upon a series of 2003 community forums regarding health system change, which found that "fairness" was the important public value for our health system. Washington State is currently ranked as 15 under the United Health Foundation's annual state ranking report. The Washington Health Foundation campaign is intended to educate and engage the public on the many changes and actions that are necessary to make us number 1. In addition, the foundation has chosen to focus on access to care for the state's most vulnerable populations as one of its major contributions to the overall campaign.
- The **Healthy Communities Access Program**, a project of the U.S. Health Resources and Services Administration, supports the work of communities to provide "safety net" services for the uninsured and underinsured. The goal is to reorganize health care delivery systems to coordinate more sharing of uncompensated care among local health care providers. Five projects have received funding to do this

### **The Whatcom Alliance Access Project**

This collaboration of the Whatcom County Health Department, health care providers, community groups, local businesses, and consumers works to increase health services access. Its key components are:

#### **Outreach—**

- Developing a user-friendly website and health outreach materials
- Establishing a network of trained volunteers to ensure Medicaid enrollment
- Placing professional outreach workers strategically in venues such as hospital emergency departments

#### **Systems re-design, care coordination and case management—**

- Improving care management and clinical staff productivity by implementing open access scheduling at participating community clinics
- Improving clinical outcomes for low-income, underserved patients

#### **Develop a system of managed, donated specialty care—**

- Establishing a specialist recruitment program for donated services
- Establishing a shared database that can be used by community clinics to ensure that all qualifying patients have equal access to needed specialty care

#### **Long-term system capacity building—**

- Establishing a community-based physician recruitment and retention program
- Creating a public-private partnership to sustain community-based access initiatives

work in Washington. In Spokane, for example, the project has developed a provider network that will take uninsured patients on a rotation basis, and it supports a referral system from the emergency room to primary care. Partners in this effort include local health departments, public hospitals, community health centers, universities, and state governments.

- **Communities Connect** is a statewide collaboration of concerned community members and leaders who are working together to improve access to care. This work fosters grassroots efforts to promote health system change, supports information-sharing on solutions to health care problems, provides technical assistance to communities, and develops shared objectives for local, state, and federal policy.
- Clark County's **Community Choices 2010** brings together local partners to assess regularly demographic and health data with the overall purpose of building awareness and support for the community's health. This work has focused on several health issues, such oral health, adult smoking, teen pregnancy, and the uninsured. A community report card provides information in 33 indicator areas, including new categories of social connectedness, educational health (readiness to learn), and violence and injury (domestic violence).

Community-based work on access has engaged other Washington counties, including Benton-Franklin, Clallam, Jefferson, Kittitas, Thurston, Spokane, and Whatcom (see page 42 and

Appendix 12). The focus of this work changes over time, as new health issues or diseases emerge. Among the issues addressed so far are maternity care access, oral health, mental health, and provider shortages. Recognizing that other county efforts are underway, the committee will collect and describe examples of successful projects throughout the state.

One of the greatest challenges the Access Committee faces is finding ways to work with health system elements that are outside of the public health system, such as reimbursement through Medicare and Medicaid. Or, transportation, which must be accessible and available for low income populations—especially in rural and sparsely populated areas—for access to health services to be possible. Work to ensure access to care must also recognize the presence of health disparities across ethnic and racial groups in the state, as discussed in the Key Indicators work in Chapter 1. Finally, health care workforce issues are also critical: we need an adequate supply of health professionals, and as a group, they need to be representative of diverse populations.

In addition, the committee has learned there is no one-size-fits-all solution to improving access to critical health services. Each of Washington's 35 local public health jurisdictions has a different level of involvement with access-related issues, reflecting unique community resources, opportunities, and circumstances. Achieving greater access to critical health services in Washington's communities will depend on a host of local variables, including provider recruitment and retention, engagement of community leaders, addressing health workforce shortages, and the many demographic characteristics that affect demand for care.

## Recommendations for 2005-07

1. Collect and analyze community success stories.

Using a common set of data elements and characteristics, collect and share models of community-based and statewide efforts to address critical health service access.

Many local health jurisdictions have stories to tell of their involvement in their communities on projects that focus on access. A Resource Guide of Models or Practices will be compiled and made available via web and hard copy. Data about health services should reflect a broad understanding of health, including underlying determinants of health.

2. Communicate lessons learned.

Find opportunities and forums to present findings and discuss the access standards work. Linking this work with PHIP communications efforts has great potential to expand the audience for public health's messages concerning community health improvement. The media covers health care access issues on a routine basis. Engaging the media to expand their focus to services other than personal medical care will stimulate needed debate on the true determinants of health and wise use of limited health care resources. Conferences such as the Joint Public Health Conference, Healthy Communities, the Washington Rural Health Association and others are places to share models of work to improve access.

3. Promote integration of and availability of data across programs.

Several Department of Health programs, other state programs, and private foundations collect data. The data collected on the key indicators for the state Report Card on health need to be integrated with these

data systems. Analysis may be done at the local or state level and shared with other agencies or with local health departments. These data are often used to support grant funding. The website [AssessNow.info](http://www.AssessNow.info) provides an opportunity to present data and analysis as well as studies on-line, making them accessible to local health jurisdictions and others (see <http://www.AssessNow.info>).

4. Look for additional resources to build on this work.

Help find resources to pilot, expand, or sustain models of implementing access standards at both the state and local level. Often, grant funds are available at the federal, state, and local level as well as through private foundations and charitable organizations. Some of the state's more notable access projects are based on creative local partnerships sustained by donated resources of community partners.

5. Develop long-term policy with respect to critical health services.

Among the elements of this work will be to explore further the central organizing role that local health jurisdictions can play in assuring community-based access to critical health services, with particular attention to population-based and clinical preventive services. It will be necessary to prioritize and focus efforts on services that are evidence-based and offer the greatest community benefit. The work of the SBOH can be built on to collect data about critical services. The committee will also begin to identify high-priority and feasible surveillance systems for use in determining access gaps at both state and local levels. These services can then be linked to existing quality improvement and safety efforts in the health care delivery sector.



# EFFECTIVE COMMUNICATION: IMPROVING UNDERSTANDING OF PUBLIC HEALTH

Most of the work that has engaged the Communications Committee during the past four years addresses a simple quandary: People value what public health agencies do, but they don't often understand the context in which they do it. They appreciate that public entities protect them from dangers they cannot control—such as communicable disease, unsafe food and water, and other environmental hazards. But they are unlikely to recognize the necessity of maintaining a complex government system, supported by research and regulatory infrastructure, to do the job.

To secure this vital connection—between widely valued public health services and the agencies that provide them—the Communications Committee during the past two years has overseen development of a range of focused activities designed to clarify and reinforce the core mission of the state's public health system: Always working for a safer and healthier Washington.

During the past two years, these activities have included a web-based public health communications “toolkit,” including resources for public health employees to use when they interact with people in their communities, on the web, and through the news media. These tools include fact sheets, a brochure, and public service advertisements that can be customized for use in a variety of settings. The website

(<http://www.doh.wa.gov/phip/communications/tools>) also provides straightforward language that public health professionals can use to explain succinctly the essential work they do in ways that people understand and value.

Training is provided for public health workers, at all levels of work, so they can describe clearly the benefits of public health services. An “e-newsletter” informs public health workers about the availability of new communication tools and how to use them.

Communication strategies should increase the consistency, frequency, and impact of messages reinforcing the credibility and accountability of the state public health system.

This effort builds largely on research conducted in 2001, which revealed broad support for the work of public health but also exposed a continuing identity problem for Washington's governmental health system: Few state residents think of public health when asked about government health programs. Instead, they associate public health with medical services and programs for low-income people. Yet when asked, they place high value on public health services, such those described in Appendix 6.

Over the next two years, the Communications Committee will direct its efforts to providing

*Continued on page 47*



*People value what public health agencies do, but they don't often understand the context in which they do it.*

## Creating a Visible Presence

Public health workers are active throughout their communities on a daily basis. But the business of “prevention” is often hard to see, so the Communications Committee is exploring ways to give public health a visible presence. Public health employees are encouraged to wear articles of clothing that carry the “brand” of Washington’s public health system. They have found them to be remarkably effective at raising the profile of their work, as one employee attests:

“We use the vests and hats throughout all our programs: environmental health, communicable disease, to name just two. They were very helpful during our flood effort last winter. When you are one of several agencies at the emergency operations center, walking around a flooded area, giving tetanus shots, etc., it is important for people to know that it’s us out there doing public health work.”

—Corinne Story, Environmental Health Director,  
Skagit County Public Health Department



## When They Know What It Is, They Support It

As part of the initial research into communications strategies, the Communications Committee asked Washington residents what came to mind when they were asked about “public health.” Their responses revealed a generally poor understanding. But once people were informed of the services public health provided, they indicated strong support and enthusiasm. Among typical responses were:

“If public health doesn’t do it, who will?”

“It made me think of Hanford. I expect someone to be responsible for our health and safety and issues like that.”

Among people who have worked with public health agencies directly, such as elected officials, we found both solid understanding and strong support:

“Public health is not an optional program. It’s a fundamental issue of government, no matter what your politics.”

“Investigation of communicable disease is undervalued because there are so few of them. But there are so few of them because the investigation work is well done.”

“Public health is data-based and can document health outcomes. No other government enterprise is as clearly focused on demonstrable outcomes.”

*Continued from page 45*

public health leaders with advanced communications training so they become familiar with better ways to communicate the value of public health and become more available to and accountable with their communities and the news media. A new approach will be to share

some of the stories generated across Washington State every day, to illustrate both the routine and creative ways the state public health workforce works to keep residents healthy and safe.

## Recommendations for 2005-07

1. Conduct advanced workforce training to strengthen understanding of public health.

The committee will conduct a round of advanced communications training to develop workforce skills in communicating the value and benefit of public health through the media, community organizations, and service groups. They will begin the series with top management in public health agencies.

2. Adopt a set of communication strategies that will achieve broader understanding of public health goals.

The public will gain a greater understanding of public health services if all agencies put forward a clear and consistent message about what public health does, how it serves and protects people, and how it informs them about how they can participate in public health efforts.

3. Collect and tell public health “stories” that illustrate how public health affects everyone who lives in or visits Washington.

Stories provide the most effective way to communicate a memorable message. Public health workers have many interesting, even dramatic, stories to tell that illustrate how public health is “always working for a safer and healthier community.” Collecting and sharing written stories will be helpful in achieving a broader public understanding.

4. Conduct a statewide media event to increase public understanding.

Beginning with the series of five communications workshops from January through March 2005, the committee will organize statewide participation in a coordinated public health “event” to engage the media in increasing public understanding of public health services and the agencies that deliver them. This event could take place during Public Health Week, in early April.

# APPENDICES

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# APPENDIX 1: PHIP COMMITTEES

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# APPENDIX 2: LIST OF KEY HEALTH INDICATORS

## Category or Domain and Indicators

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### HOW HEALTHY ARE WE OVERALL?

How good is our general physical and mental health?

Expected years of healthy life at age 20

Percent of adults who report 14 or more days of poor mental health in the past month

### Are we a healthy weight?

Percent of adults who are obese

Percent of 10th-graders who are overweight

---

### HOW SAFE AND SUPPORTIVE ARE OUR SURROUNDINGS?

Do we have illnesses commonly associated with unsafe food, unsafe water, and poor hygiene?

Rate of campylobacteriosis per 100,000 population

Rate of E.coli 0157:H7 infection per 100,000 population

Rate of giardiasis per 100,000 population

Rate of listeriosis per 100,000 population

Rate of salmonellosis per 100,000 population

Rate of shigellosis per 100,000 population

Rate of vibriosis (non-cholera) per 100,000 population

Rate of yersiniosis per 100,000 population

### Do we have clean drinking water?

Percent of the population whose homes receive water from Group A public water systems in compliance with nitrate monitoring requirements

Percent of the population whose homes receive water from Group A public water systems in compliance with quality standards for nitrates

Percent of the population whose homes receive water from Group A public water systems in compliance with coliform monitoring requirements

Percent of the population whose homes receive water from Group A public water systems in compliance with quality standards for coliform bacteria

(Indicator for Group B systems under development)

Data not included in Report Card at this time

## Category or Domain and Indicators

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### Do we have clean air to breathe?

Percent of population breathing air that is meeting the National Ambient Air Quality Standards

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## HOW SAFE AND SUPPORTIVE ARE OUR COMMUNITIES?

### Do our incomes meet basic financial needs?

Percent of Washington State households with incomes less than twice the U.S. poverty level (incomes less than 200% of the U.S. poverty level)

### Are we connected to our communities?

Percent of adults reporting that most people can be trusted

Percent of high school students dropping out of school

Rate of serious violent crime offenses per 100,000 population

### Are we getting injured unnecessarily?

Unintentional motor vehicle deaths per 100,000 population

Unintentional poisoning deaths per 100,000 population

Unintentional drowning deaths per 100,000 population

Unintentional fall-related deaths among persons 65 years and older per 100,000 population

---

## HOW SUPPORTIVE IS OUR HEALTH CARE SYSTEM?

### Are we able to get medical care when we need it?

Percent of households unable to obtain health care or experiencing a delay or difficulty in obtaining health care

### Do we have illnesses that could be prevented by immunization?

Rate of hepatitis A per 100,000 population

Rate of hepatitis B per 100,000 population

Rate of measles per 100,000 population

Rate of mumps per 100,000 population

Rate of pertussis per 100,000 population

Rate of polio per 100,000 population

Rate of rubella per 100,000 population

Rate of tetanus per 100,000 population

Data not included in Report Card at this time

## HOW SAFE AND SUPPORTIVE ARE OUR FAMILIES?

### Are we planning for and spending time with our families?

Percent of pregnancies that were intended

Percent of families that regularly read to their young children

Percent of youth who report eating dinner with their family most of the time or always

### Are our families safe?

Number of offenses involving domestic violence per 1,000

Number of reports of children younger than 18 who were abused or neglected per 1,000 population

---

## HOW HEALTHY ARE OUR BEHAVIORS?

### Do we smoke cigarettes?

Percent of adults reporting current cigarette smoking

Percent of 10th-graders who report smoking cigarettes in the past 30 days

Percent of women who report smoking during the last three months of pregnancy

### Are we physically active?

Percent of 10th-graders who report meeting recommendations for vigorous physical activity

Percent of adults meeting recommendations for moderate or vigorous physical activity through work or leisure

### Are we eating right?

Percent of adults who report eating fruits and vegetables five or more times per day

Percent of 10th-graders who report eating fruits and vegetables 5 or more times per day in the past week

Percent of 10th-graders who report drinking two or more non-diet sodas yesterday

### Do we abuse alcohol?

Percent of adults who report having five or more drinks on one occasion during the past 30 days

Percent reporting chronic drinking in the past 30 days: women who report more than one drink per day and men who report more than two drinks per day

Percent of 10th-graders who report drinking any alcohol in the past 30 days



# APPENDIX 3: SAMPLE REPORT CARD— GRADING RATIONALE

Below is a description of the rationale for each grade assigned in the example of the Report Card shown on page 17. A more complete example of the Report Card and a description of grading criteria can be found at <http://www.doh.wa.gov/hip/Indicators/DraftReportCard.htm>.

		Comparison to United States	
How healthy are we overall?	Indicator	Grade	
How good is our general physical and mental health?	Expected years of healthy life at age 20	A	Expected years of healthy life at age 20 was higher in Washington than in the United States for 1999, 2000, and 2001.
	Percent of people experiencing poor mental health for 14 or more days in one month	B	Similar percentages of adults in Washington and the U.S. reported 14 or more days of poor mental health in 2001 and 2003. In 2002, fewer adults in Washington reported 14 or more days of poor mental health.
	General health grade: Although Washington compares favorably to the United States on healthy life expectancy and mental health, we have not seen improvement since 1993, and there are moderate levels of disparities.		
Are we a healthy weight?	Percent of adults who are obese	B	Fewer adults in Washington were obese in 2001 and 2003 than in the United States. Similar proportions were obese in 2002.
	Percent of 10th-graders who are overweight	B	For the 1998/99 and 2002/03 school years, there was less obesity among 10th graders in Washington compared to the United States.
	Obesity grade: Washington has relatively fewer obese adults and overweight 10th-graders compared to the United States Nonetheless, in 2003, about 20% of adults reported heights and weights indicating obesity. About 10% of 10th-graders were overweight in 2002. Washington's rates are moving in the wrong direction, and we have moderate levels of disparities.		

				Final grade average
Trend		Disparities		
Grade		Grade		
C	There have not been significant changes in the expected years of healthy life from 1993 to 2002.	C	Disparities for years of healthy life cannot be computed directly at this time. But there is a 103% disparity between American Indian/Alaska Native (23%±5%) and Asian/Pacific Islander (11%±4%) for having poor or fair health. There is also a 9-year difference in life expectancy between Asian/Pacific Islander (83 years) and American Indian/Alaska Native (74 years).	2.7
C	There have not been significant changes in the percent of adults in Washington reporting 14 or more days of poor mental health from 1993 to 2003.	C	112% difference between American Indian/Alaska Native (14%±4%) and African Americans (7%±2%) for 2001-2003. This level of disparity is similar to the level in 1995-1997 and 1998-2000.	2.3
				2.5
F	Since 1990, the percent of obese adults in Washington has been increasing.	C	There was a 179% difference between African Americans (29%±6%) and Asian/Pacific Islanders (11%±3%) for 2001-03. This is similar to the percent differences for 1995-97 and 1998-2000.	1.7
	With only two years of data, a trend cannot be calculated.	C	There was a 115% difference between Hispanics (16%±4%) and Asian/Pacific Islanders (7%±3%) in 2002. Numbers are too small for race breakdowns in earlier years.	2.5
				2.1

# APPENDIX 4: CROSSWALK OF CORE FUNCTIONS AND 10 ESSENTIAL SERVICES TO STANDARDS

The following matrix compares the federal framework of 10 Essential Services of Public Health with the *Standards for Public Health in Washington State*. Local and state health officials drafted the standards with frequent reference to the 10 Essential Services, but they did not use the federal framework to organize their work. Instead, they chose to develop standards in five topic areas. For each area, they sought to assure that the 10 Essential Services were addressed. Please note that the standards, as referenced here, are abbreviated. An entire standard and its measures must be read to understand its scope.

The 10 Essential Services are:

## Assessment

- Monitor health status of the community.
- Diagnose and investigate health problems and hazards.
- Inform and educate people about health issues.

## Policy Development

- Mobilize partnerships to solve community problems.
- Support policies and plans to achieve health goals.

## Assurance

- Enforce laws and regulations to achieve health goals.
- Link people to needed personal health services.
- Ensure a skilled public health workforce.
- Evaluate effectiveness, accessibility, and quality of health services.
- Research and apply innovative solutions.

## 10 Essential Services

Topic Area/Standard	Assessment			Policy dev't		Assurance				
	Monitor	Investigate	Inform	Mobilize	Policies	Enforce	Services	Workforce	Evaluate	Research
<b>Assessment</b>										
1. Assessment skills and tools in place	X	X						X		
2. Information collected, analyzed, and disseminated	X	X	X		X			X	X	
3. Effectiveness of programs is evaluated	X							X	X	X
4. Health policy reflects assessment information			X	X	X					
5. Confidentiality and security of data protected								X		
<b>Communicable disease</b>										
1. Surveillance and reporting system maintained	X	X	X			X		X		X
2. Response plans delineate roles			X	X				X		
3. Documented investigation and control procedures		X			X	X	X	X	X	
4. Urgent messages communicated quickly			X	X			X	X		
5. Response plans routinely evaluated			X					X	X	X
<b>Environmental health</b>										
1. Environmental health education planned		X	X	X				X		
2. Response prepared for environmental threats	X	X		X			X	X	X	
3. Risks and events tracked and reported	X		X	X					X	X
4. Enforcement actions taken for compliance						X		X		
<b>Prevention/health promotion</b>										
1. Policies support prevention priorities	X	X	X		X			X		X
2. Community involvement in setting priorities			X	X	X					
3. Access to prevention services			X	X			X	X	X	X
4. Prevention, early intervention provided				X	X		X	X		
5. Health promotion activities provided			X	X	X			X	X	X
<b>Access to critical services</b>										
1. Information on service availability	X		X				X			
2. Information shared on trends, over time		X	X						X	X
3. Plans developed to reduce specific gaps			X	X	X		X		X	
4. Quality and capacity monitored and reported			X			X		X	X	X

# APPENDIX 5: ENVIRONMENTAL HEALTH STANDARDS

The *Standards for Public Health in Washington State* include one set of standards that cover environmental health, referred to as “Assuring a safe and healthy environment for people.” During 2004, environmental health directors from several local health jurisdictions worked with staff from the Washington State Department of Health to revise some of the measures. These revised measures will be used in the 2005 standards measurement.

## Standard EH1

Environmental health education is a planned component of public health programs.

### Local measures:

- EH1.1L Information is available about environmental health, including compliance requirements, through brochures, flyers, newsletters, websites, or other mechanisms.
- EH1.2L The community and stakeholders are involved in appropriate ways in addressing environmental health issues, including through presentations or individual technical assistance.
- EH1.3L Environmental health education information in all forms (including technical assistance) is reviewed at least annually and updated, expanded or contracted as needed based on revised regulations, changes in community needs, etc.
- EH1.4L The critical components of all environmental health activities are identified and used as the basis for education that is provided. Workshops and other in-person trainings (including technical assistance) are evaluated to determine effectiveness.

### State measures:

- EH1.1S Information is provided to the public about the availability of state level environmental health through brochures, flyers, newsletters, websites, or other mechanisms.
- EH1.2S Stakeholders are involved in appropriate ways in addressing environmental health issues, including through presentations or technical assistance.
- EH1.3S Environmental health education information in all forms (including technical assistance) is reviewed at least annually, and is updated, expanded, or contracted as needed based on revised regulations, changes in stakeholder needs, etc.
- EH1.4S Environmental health education is provided in conformance with needs of stakeholders, as identified through meetings, surveys, or other assessment means. Environmental health education is assessed for effectiveness through evaluations of participants, surveys, or other means.
- EH1.5S Staff members conducting environmental health education have skills (health education, communication, etc.) as evidenced by job descriptions, resumes, or training documentation.

## Standard EH2

Services are available throughout the state to respond to environmental events or natural disasters that threaten the public's health.

### Local measures:

- EH2.1L Information is provided to the public on how to contact local jurisdictions to report environmental health threats or



public health emergencies 24 hours a day.

- EH2.2L Environmental health threats and public health emergencies are included in the local emergency response plan. After a public health emergency response involving environmental health occurs, environmental health staff are included in the local jurisdiction after-action debrief. Any changes to the response plan affecting environmental health response are documented.
- EH2.3L Environmental health services that are critical to access in different types of emergencies are identified. Public education and outreach includes information on how to access these critical services. After-action debrief includes a review of the accessibility of those services, and any changes necessary are made and documented.
- EH2.4L There is a plan that details the roles and responsibilities for local health jurisdiction staff in a natural disaster or other public health emergency that both stands alone and is part of the local emergency response plan. All local health jurisdiction staff receive annual training on their respective duties.

#### State measures:

- EH2.1S Information is provided to the public on how to report environmental health threats or public health emergencies, 24 hours a day; this includes a phone number.
- EH2.2S Environmental health threats and public health emergencies are included in the emergency response plan. After a public health emergency response involving environmental health occurs, environmental health staff are included in the after-action debrief. Any changes to the response plan affecting environmental health response are documented.
- EH2.3S Written procedures are maintained and disseminated for how to obtain consultation and technical assistance

regarding emergency preparedness for environmental events or natural disasters that threaten the public's health. Procedures are in place to evaluate the effectiveness of these emergency response plans. Plans or procedures are revised based on event debriefing findings and recommendations.

- EH2.4S There is a plan that describes Department of Health internal roles and responsibilities for environmental events or natural disasters that threaten the health of the people. There is a clear link between this plan and other state and local emergency response plans.
- EH2.5S Appropriate Department of Health program staff are trained in risk communication and the DOH emergency response plan, as evidenced by training documentation.

#### Standard EH3

Both environmental health risks and environmental health illnesses are tracked, recorded, and reported.

#### Local measures:

- EH3.1L Environmental health data are available for community groups and other local agencies to review.
- EH3.2L Key indicators of environmental health risks and illnesses are identified. A system is in place for reporting of any suspected environmental health illnesses based on those indicators, and reporting is tracked to monitor trends. A system is in place to assure the data are shared with appropriate local, state and regional agencies.
- EH3.3L Public requests, board of health testimony, compliance rates, and other data and information are used to determine what internal or external quality improvements may be needed. If needed, a plan is developed to institute needed changes over time.

### State measures:

- EH3.1S Coordination to develop environmental health indicators and data standards is provided.
- EH3.2S Key indicators of environmental health risks and illnesses are identified. A system is in place for reporting of any suspected environmental health illnesses based on those indicators, and reporting is tracked to monitor trends. A system is in place to assure the data are shared with appropriate local, regional, state, and national agencies.
- EH3.3S Public requests, testimony before the State Board of Health, compliance rates, and other data and information are used to determine what internal or external quality improvements may be needed. If needed, a plan is developed to institute changes over time.

### Standard EH4

Compliance with public health regulations is sought through enforcement actions.

### Local measures:

- EH4.1L Written policies, local ordinances, administrative codes, and enabling laws are accessible to the public.
- EH4.2L There are written procedures to follow for enforcement actions. The procedures specify the type of documentation needed to take an enforcement action, which conforms with local policies, ordinances, and state laws.
- EH4.3L A selected number of enforcement actions are evaluated each year to determine compliance with and effectiveness of enforcement procedures. If needed, procedures are revised.

- EH4.4L Enforcement actions are logged (tracked) from the initial report, through the investigation, findings, and enforcement action and are reported to other agencies as required.
- EH4.5L Appropriate environmental health staff are trained on enforcement procedures.

### State measures:

- EH4.1S Written policies, local ordinances, laws, and administrative codes are accessible to the public.
- EH4.2S Information about best practices in environmental health compliance activity is gathered and disseminated or posted to agency's website, including, as appropriate, form templates, time frames, interagency coordination steps, hearing procedures, citation issuance and documentation requirements.
- EH4.3S There are written procedures to follow for enforcement actions. The procedures specify the type of documentation needed to take an enforcement action, which conforms with state law.
- EH4.4S There is a documented process for periodic review of enforcement actions and a selected number of enforcement actions are evaluated each year to determine compliance with and effectiveness of enforcement procedures. If needed, procedures are revised.
- EH4.5S Enforcement actions are logged (tracked) from the initial report through the investigation, findings, and enforcement action, and they are reported to other agencies as required.
- EH4.6S Appropriate environmental health staff are trained on enforcement procedures, as evidenced by training documentation.

# APPENDIX 6: LIST OF SERVICES TO ‘COST’ THE STANDARDS

Following are the core public health activities and services that a mid-size health jurisdiction would provide to meet 95% performance on the *Standards for Public Health in Washington State*.

## Assuring a safe and healthy environment

- Food safety (inspections, education, permitting, data management including local responsibilities for shellfish monitoring)
- Water recreational facility safety (inspections, education, permitting, data management)
- Hazardous materials management (drug lab inspection, testing oversight, clean-up oversight)
- Solid waste management (permitting, inspection, enforcement, education)
- Water quality control: sewage (permitting, inspection, enforcement, education and operations and management), ground water, drinking water (permit, inspection, enforcement, education, drinking water data), surface water (drinking water permit, inspection, enforcement, education, and environmental monitoring)
- Vector/rodent control/zoonotic disease (inspection, enforcement, education, and sampling)
- Air quality monitoring (indoor investigations)
- Environmental laboratory services
- School safety (inspection, education, and consultation)
- Environmental health community involvement
- Environmental sampling
- Review of land use decisions

## Protecting people from disease

- Detection/case investigation: screening (specimen collection and analysis),

testing, lab (identification and diagnosis), diagnosis (clinical and lab identification)

- Surveillance, reporting (transmission of information), data analysis (monitor and interpret), data gathering (collecting information and collection systems), epidemiological investigations, case finding (identifying cases and location), contact tracing (identifying potential exposure)
- Regional epidemiology
- Laboratory (identification and diagnosis)
- System intervention: immunizations (preventive pre- or post-exposure), treatment and prophylactic treatment (dispensing, shots, application, and observation), counseling (one-on-one education and therapy), tuberculosis program
- Public and provider education (informing general public and outbreak specific)
- Surveillance of chronic disease trends and behavioral changes, identifying clusters, special studies to identify risk factors and focus prevention efforts, prevention activities focused on behavioral and environmental/policy interventions, and evaluation
- Outreach and prevention with high-risk populations
- Plans and surge capacity for response to emergency situations that threaten the health of people

## Understanding health issues

- Epidemiology (infectious and non-infectious disease trends monitoring, collection, and analysis of data on health risk behaviors, health status, and critical health services)
- Dissemination of assessment information in the community to support decision-making

- Technical assistance, education and leadership for community-level data utilization

### Evaluation of public health program results

- Prevention is best: promoting healthy living
- Capacity for health education and systems work related to the following activities: engaging community agencies, organizations and constituencies to address and develop locally designed programs driven by locally identified health issues, strategic planning based on community needs, local data gathering and analysis, and coalition and stakeholder-building
- Resource assessments (develop assessment of resources based on specific needs), generate resources (design materials, find funding, write grants), designing and providing promotional materials and/or social marketing campaigns evaluating results of efforts, and collecting and disseminating research-based best practices
- Assure and support healthy pregnancy, healthy birth outcomes, early brain development; includes maternal and child health programs, early intervention, health and safety promotion in child care centers, children with special health care needs, family planning, First Steps/MCM/MSS community outreach and WIC
- Evaluating results of efforts, collecting and disseminating research-based, replicable best practices (including about chronic illnesses and health behaviors), provider and public education

### Helping people get the services they need

- System assurance role: bring people together and provide leadership and support, system infrastructure, support for local community SWOT assessment
- Provide information and education about critical public health services; create conditions that make action possible.
- Information and referral activities (maintain inventory of services, referral, resource broker)
- Create conditions that make action possible (standards, policy, quality assurance, materials and supplies, information, and education)
- Safety net services (direct services as identified through local assessment, Menu of Critical Health Services)

### Administration

- Leadership, planning, policy development, and administration
- Financial and management services (accounting, budget, contracts, procurement, grants, and asset management)
- Leadership and governance (communication, public relations, relationship building, program planning, and fundraising)
- Legal authority (policies, procedures, and regulations)
- Human resources (personnel, employee development and recognition, compensation and benefits management, and employee policies)
- Information systems (hardware/software systems, networking, data sharing, policies)

# APPENDIX 7: PHIP LAWS

## RCW 43.70.520

### Public health services improvement plan.

(1) The legislature finds that the public health functions of community assessment, policy development, and assurance of service delivery are essential elements in achieving the objectives of health reform in Washington state. The legislature further finds that the population-based services provided by state and local health departments are cost-effective and are a critical strategy for the long-term containment of health care costs. The legislature further finds that the public health system in the state lacks the capacity to fulfill these functions consistent with the needs of a reformed health care system.

(2) The department of health shall develop, in consultation with local health departments and districts, the state board of health, the health services commission, area Indian health service, and other state agencies, health services providers, and citizens concerned about public health, a public health services improvement plan. The plan shall provide a detailed accounting of deficits in the core functions of assessment, policy development, assurance of the current public health system, how additional public health funding would be used, and describe the benefits expected from expanded expenditures.

(3) The plan shall include:

(a) Definition of minimum standards for public health protection through assessment, policy development, and assurances:

(i) Enumeration of communities not meeting those standards;

(ii) A budget and staffing plan for bringing all communities up to minimum standards;

(iii) An analysis of the costs and benefits expected from adopting minimum public health standards for assessment, policy development, and assurances;

(b) Recommended strategies and a schedule for improving public health programs throughout the state, including:

(i) Strategies for transferring personal health care services from the public health system, into the uniform benefits package where feasible; and

(ii) Timing of increased funding for public health services linked to specific objectives for improving public health; and

(c) A recommended level of dedicated funding for public health services to be expressed in terms of a percentage of total health service expenditures in the state or a set per person amount; such recommendation shall also include methods to ensure that such funding does not supplant existing federal, state, and local funds received by local health departments, and methods of distributing funds among local health departments.

(4) The department shall coordinate this planning process with the study activities required in section 258, chapter 492, Laws of 1993.

(5) By March 1, 1994, the department shall provide initial recommendations of the public health services improvement plan to the legislature regarding minimum public health standards, and public health programs needed to address urgent needs, such as those cited in subsection (8) of this section.

(6) By December 1, 1994, the department shall present the public health services improvement plan to the legislature, with specific recommendations for each element of the plan to be implemented over the period from 1995 through 1997.



(7) Thereafter, the department shall update the public health services improvement plan for presentation to the legislature prior to the beginning of a new biennium.

(8) Among the specific population-based public health activities to be considered in the public health services improvement plan are: Health data assessment and chronic and infectious disease surveillance; rapid response to outbreaks of communicable disease; efforts to prevent and control specific communicable diseases, such as tuberculosis and acquired immune deficiency syndrome; health education to promote healthy behaviors and to reduce the prevalence of chronic disease, such as those linked to the use of tobacco; access to primary care in coordination with existing community and migrant health clinics and other not for profit health care organizations; programs to ensure children are born as healthy as possible and they receive immunizations and adequate nutrition; efforts to prevent intentional and unintentional injury; programs to ensure the safety of drinking water and food supplies; poison control; trauma services; and other activities that have the potential to improve the health of the population or special populations and reduce the need for or cost of health services.

[1993 c 492 § 467.]

### RCW 43.70.580

Public health improvement plan—Funds—Performance-based contracts—Rules—Evaluation and report.

The primary responsibility of the public health system, is to take those actions necessary to protect, promote, and improve the health of the population. In order to accomplish this, the department shall:

(1) Identify, as part of the public health improvement plan, the key health outcomes sought for the population and the capacity needed by the public health system to fulfill its responsibilities in improving health outcomes.

(2)(a) Distribute state funds that, in conjunction with local revenues, are intended to improve the capacity of the public health system. The distribution methodology shall encourage system-wide effectiveness and efficiency and provide local health jurisdictions with the flexibility both to determine governance structures and address their unique needs.

(b) Enter into with each local health jurisdiction performance-based contracts that establish clear measures of the degree to which the local health jurisdiction is attaining the capacity necessary to improve health outcomes. The contracts negotiated between the local health jurisdictions and the department of health must identify the specific measurable progress that local health jurisdictions will make toward achieving health outcomes. A community assessment conducted by the local health jurisdiction according to the public health improvement plan, which shall include the results of the comprehensive plan prepared according to RCW 70.190.130, will be used as the basis for identifying the health outcomes. The contracts shall include provisions to encourage collaboration among local health jurisdictions. State funds shall be used solely to expand and complement, but not to supplant city and county government support for public health programs.

(3) Develop criteria to assess the degree to which capacity is being achieved and ensure compliance by public health jurisdictions.

(4) Adopt rules necessary to carry out the purposes of chapter 43, Laws of 1995.

(5) Biennially, within the public health improvement plan, evaluate the effectiveness of the public health system, assess the degree to which the public health system is attaining the capacity to improve the status of the public's health, and report progress made by each local health jurisdiction toward improving health outcomes.

[1995 c 43 § 3.]



# APPENDIX 8: DEVELOPING ESTIMATES OF COST TO MEET WASHINGTON'S PUBLIC HEALTH STANDARDS

## What would it take to protect the public's health according to the public health standards?

To provide public health protection by meeting the public health standards 95% of the time, Washington's governmental public health system would need a sustained annual investment of about \$400 million in addition to current resources.

- This total includes an additional investment of \$14.5 million toward Department of Health (DOH) efforts to provide public health protection. The larger proportion of this estimate would be focused on ensuring assessment skills and tools are in place, that program evaluations are conducted, and for health promotion activities.
- The total also includes \$385 million above current public health capacity for 35 LHJs to meet the standards at 95% capacity.

## Background

The *Standards for Public Health in Washington State* describe what public health professionals believe everyone has a right to expect of the governmental public health system. The standards were developed jointly by state and local public health officials and field-tested over time. A 2002 baseline measured the capability of the state agency and the 35 local public health agencies to meet the standards; the study shows how far the partners in the system are from being able to perform the standards statewide.

## Why “cost” the standards?

Standards provide:

- A clear and accountable measure of performance for public health agencies—a level of protection citizens can count on.
- Information to health policy makers about the operational “health” of the system as well as the effectiveness of public health interventions.
- A way to evaluate on a regular basis where public funds are needed, what they are buying, and how well they are being spent.
- By estimating what it would cost to achieve the standards statewide, the standards can be used to link state and local funding with meeting public health standards and improving health outcomes. Over time, costing the standards helps to meet the system goal of stable and sufficient funding for public health.

## General assumptions used to cost the standards

- The standards are what the public health system believes that the state and every local health jurisdiction must be able to do to protect and promote the health of people. The cost of meeting the standards will not rest with the measures themselves but with the underlying capacity it takes to demonstrate performance.
- The estimates should lead to recommendations for funding priorities in public health.

*Continued on page 74*

## Methodology for ‘Costing’ the Standards

# LOCAL

### IDENTIFY “CORE” ACTIVITIES

Identify the “big idea”  
behind each standard

- Vital services, protection, outcomes, deliverables
- Recognize a service could cut across multiple standards and vice versa.

### Develop mid-size LHJ cost estimate

- Matrix: “core” services x big ideas behind each standard, showing relationship between service and standard.
  - o April: Distribute matrix to 8 LHJs:
    - \* Joint Finance-Standards Committee (Island, Jefferson, Clark, Spokane)
    - \* Four LHJs near population 175,000 (Chelan-Douglas, Benton-Franklin, Whatcom, Thurston).
- LHJs estimate the number of professional FTEs (direct costs) needed to successfully meet 95% performance of the standards for a jurisdiction serving population 175,000 (the average population of all current 35 jurisdictions). This mid-size jurisdiction is the starting point and basis for costing standards at the local level. Technology may be separately estimated.
- Staff will synthesize and share FTE estimates and report exceptions.
- LHJ reps confirm and resolve remaining differences.
- Complete mid-size LHJ cost estimate by multiplying:
  - o Direct FTEs by estimated salaries;
  - o Direct FTEs by support and management ratio for span of control;
  - o All FTEs by percentage overhead factor.
- Centrally add costs for tools, training, overhead, and supporting staff (management and administration) on percentage basis and by span-of-control formula.
- **Sum: the cost for a mid-size LHJ to meet standards at 95% performance.**

# STATE

### Start with the gap

- Use “Proposed Matrix” of DOH assignments of divisional responsibility to meet the standards as a starting point. **Focus on the gap between what was measured and what it would take to improve DOH performance to 95% of standard.**
- Seek key informants to be identified by senior management team.

### Scale the estimate and aggregate statewide

- Use the cost for a mid-size LHJ as the starting point and 2002 population.
- Use the four categories of local health jurisdiction types (Rural-Urban Commuting Area) outlined in the baseline evaluation to group to classify LHJs and establish relationship of each LHJ to mid-size. Multiply costs by scaling factor and aggregate costs statewide.
- Implications: LHJs with 10x population will have 10x cost; those with 0.1x the population will have that fraction of cost. Acknowledge that estimates may need to be adjusted for outliers (such as separate estimate for Public Health—Seattle & King County).
- **Sum: the cost for all LHJs to meet the standards at 95% performance.**
- Test costs by consulting LHJs that performed well in 2002. Interview them and see how they rate and would improve the estimate.

### Estimate the gap

- **Use the estimate for total funds needed system-wide and subtract current resources** (2002 BARS estimate) to give the amount of additional resources needed (the “gap”) to meet the standards.
- Ensure the estimate allows for flexibility to respond to public health priorities.

### Estimate cost for DOH to meet standards

- Schedule individual meetings for key informants in four divisions: CFH, Epi/Lab, HSQA, and EH, to develop models for meeting the standard at the 95% level, in terms of FTEs and the major resources needed.
- Key informants review standards for all topic areas where responsibility has been assigned for their division.
- Program managers and/or key program staff review cost estimates for their division and modify.
- DOH staff estimates costs for the remaining divisions (MSD, OS, DIRM, SBOH) and applies costs to FTE estimates. **Result: Cost for DOH to meet 95% of performance.**

### Total costs:

Local gap

+

State gap

=

**Estimated cost to meet standards statewide**

- The estimates draw on the expertise of public health professionals from both the Finance Committee and the Standards Committee. The cost estimates incorporate the best judgment of practicing professionals, applied using real-life scenarios and costs to develop formulas. Assumptions are documented so readers can easily track how cost figures were derived.
- Estimating costs should focus on *additional* resources needed to achieve public health performance standards statewide, on top of current capacity in the system, beginning with information gathered in the 2000 field test and the 2002 baseline study. Thus, additional funds needed focus on the “gap” between current performance and the performance desired to achieve the standards.
- The estimates focus on the system as a whole; state and local needs are estimated separately, but the model is not designed to be applied in a district-specific or service-specific method.
- The cost model is based on the resources public health professionals believe it will take to meet the standards, including assumptions about known costs such as salary, benefits, rent, equipment, and vehicles.
- The model and assumptions will be used to derive reasonable estimates of overall need—but they will not represent the only way or the “right” way to organize or deploy resources. The modeling work focuses on current capacity only in terms of today’s current organization of LHJs and DOH, and it did not try to figure those costs in any re-structured system. From the initial estimate, other work may be done to estimate costs using different approaches that seem to offer improved service or that promise cost savings. This effort should lead to next steps in which ways to improve our public health efforts are considered. A continued focus on

quality improvement is essential—finding ways to be more effective in terms of outcomes and more efficient in terms of costs and resources.

- Core public health activities and resources needed to provide them were estimated, based on the standards, rather than the many categorical programs that help support basic capacity. These differences are drawn because separating core from categorical activities will reveal the real cost of resources that must be in place to assure baseline public health protection.

### Costing methodology: DOH

- At DOH, the process to develop costs was sponsored and led by the senior management team and managers from across the department. Costing was based on full-time equivalent (FTE) estimates and used formula calculations for each division to calculate the total costs, which includes indirect or overhead costs, supervision and administrative support.
- These cost estimates were conducted as a separate and parallel process from the costing work done with LHJs, and they do not reflect anticipated state capacity that would be needed once LHJs are fully funded. The DOH estimates were based on the size and capacity that exists within local health at this time. A next step for DOH would be to use the local health estimates as information to re-examine the state estimates.
- Given the expectations for delivery of local public health services throughout the state and current under-funding, it would be expected that the estimates for local health would be far greater than for the state.
- From the baseline assessment, a “proposed matrix” of DOH assignments of responsibility (by standards) was refined, and DOH focused on the gap between what was measured and what it would take to improve performance in those specific areas already identified on the matrix—not

on all areas where the standards could be used.

- Program managers were encouraged to think beyond the minimum level of performance and estimate the FTE needed for a very good program.
- The process focused on FTEs and asked managers to think into the future and develop the most realistic estimate they could. The costs were calculated at the standard level and used a formula to apply costs to the new FTEs needed and add in any other extraordinary cost.
- Assumptions about making the cost estimates:
  - o Cost estimates are based on the number of new professional staff and any extraordinary costs (e.g., technical equipment, software, etc.) needed to meet the standards at 95% performance. Excluded were all administrative support staff. A consistent formula specific for each division calculated the associated costs (support and supervisory staff) and overhead.
  - o The estimates of current FTEs were based on what are expected to be in place by June 6, 2005. New FTE will assume a start date of July 1, 2005. Economies of scale will be addressed through management review. The timeframe for reaching 95% performance on the standards could be phased in over five years, with a mid-point assessment (in 2007) to determine progress toward goals and adjust calculations as necessary.
  - o Estimates are at the standards level and not at the measure level.
  - o For programs that currently receive grant funding that may not be ongoing but that allows them to accomplish the work, estimates include the number of FTEs needed to continue the work if the grant went away. These are grants that have a good chance of being discontinued.

- Given that the DOH Administrative Standards have not been finalized, they were not included in the DOH estimates.
- Detailed FTE information is not included in final reports.

### Costing methodology: local public health

- Assumptions and guidance for cost estimation was provided by a six-member group of representative LHJs from the following counties: Benton-Franklin, Clark, Island, Spokane, Thurston, and Whatcom. The estimate was calculated by Berk & Associates.
- Important public health protection and activities for each standard were selected for costing, using a matrix of services. Members of the subgroup related the matrix to the standards and estimated the total number of professional FTEs needed to carry out the activity in a jurisdiction with a population of 175,000.
- Local estimates were calculated by topic area of the standard, then aggregated by topic for the five areas. Not every standard must have a cost assigned, though most will. Cost per measure was not estimated and public health professionals believed it would be a misrepresentation to do so.
- A span of control factor was applied to each direct service FTE to estimate support and management FTE, and an index of the cost of a mid-size LHJ to meet the standards was set (\$17.5 million)
- Next, local cost estimates were scaled for size, to take into account different costs for rural or urban areas. (Example: rural areas have greater travel time and fewer appointments per day. Urban areas may have concentrated populations, but also much higher demands for service.) For this model, we adapted a calculation used in the baseline study called the Rural-Urban Commuting Area system. At this point it was decided that the scaling resulted in an

unrealistic result for Seattle-King County, and it would be estimated separately. The remaining LHJs fell into six size categories.

- Using the estimate of the total amount it would take to reach the standards, subtracted from that was the amount of funding already committed to meeting the public health standards. The result is the shortfall in LHJs to be able to fully meet the public health standards (“the gap”).
- The model to cost the standards seems to work relatively well, except for cases of very small and very large local health departments; therefore, an adjustment to the estimate was developed for Public Health—Seattle & King County (PHSKC) because the model resulted in a very low

total estimate for this jurisdiction to meet the standards. In addition, the estimate recognizes other ways to describe capacity, such as investments in contracts with community health, research, investments in partnering with the private health care industry, and developing automated records.

- All the divisions of PHSKC participated in a costing methodology similar to local health departments to estimate the cost to meet the standards for a large metropolitan health department. The agency considered areas in 2002 baseline performance that needed improvement, plus all activities that it engaged in to meet the standards.



# APPENDIX 9: SUMMARY OF PROPOSED FUNDING METHODOLOGY AND ALLOCATION PRINCIPLES

This summary is taken from a paper based on financing principles developed by the Public Health Improvement Partnership Finance Committee. The paper contains recommendations for how the Washington State Department of Health will work with local health partners in determining allocations of state-administered funds. The complete set of recommendations is available at <http://www.doh.wa.gov/phil/documents/Financing/fundingallocation/recommendations.pdf>.

## Definitions:

**Funding methodology**—The formula used to calculate an allocation

**Funding allocation**—The amount of funding distributed as a result of a funding methodology formula

## Finance system principle:

Public health funding is a shared responsibility of federal, state, and local government.

### Allocation group recommendation

- Funding methodologies and allocations will be developed jointly by the Department of Health and local health jurisdictions.
- Communication is a joint responsibility.

## Finance system principle:

Federal, state, and local funds can be used most effectively when restrictions are few, while still maintaining accountability for public health outcomes.

### Allocation group recommendation

- Use evidence of effective program strategies in allocating flexible funds.

- Options to consider when funds are unrestricted: population, level of effort needed to meet requirements, legislative intent.

## Finance system principle:

State and federal sources should be allocated based on regularly updated, well-defined/ documented/communicated, measurable characteristics.

### Allocation group recommendation

#### Selecting funding methodology:

- Evaluate the impact of a new funding method or changing an existing one.
- Review programmatic strategies in light of available dollars, allocation, and effectiveness of strategies.
- Link the purpose of funding with methodology. For example:
  - o Specific population—specific target
  - o Capacity/broad population focus—statewide population target
- Select an approach appropriate to the subject, i.e., incidence (rate) v. prevalence (number of people affected).

## Deciding allocation amounts:

- Use available assessment data at onset of allocation review. Develop a picture of what is happening with the issue being considered.

## Advisers:

- Gather input using advisers to guide decision-making.

### Regular updates:

- Schedule a methodology review every 10 years at a minimum or when there are major changes in the funding, changes in data elements of a formula, or changes in federal requirements.
- Schedule an allocation review every biennium to include new data as available, unless there are substantial changes in funding that require immediate action.

For example: If methodology is going to change, synchronize any changes with the budgeting process, if possible. When there is a difference between the funding target and current allocation, bring all LHJs to their targeted allocation. Adjustments in funding should be phased in over time to reach targets.

### Communication:

- Provide an opportunity for all affected by the allocation to be involved and “heard,” both in the development of the methodology as well as the allocation updates.
- Funding methodology and allocation process should be a participatory, transparent, and understandable process.

### Finance system principle:

Financial incentives should exist to encourage partnerships that result in less costly and most cost-effective public health service.

#### Allocation Group recommendation

- If funds are insufficient to be effective when allocated among all local health jurisdictions statewide, consider: Not distributing statewide; coordinating funding with other programs with similar goals; leveraging funds (e.g., common outcomes or statement of work); reviewing flexibility or strategies; seeking more funding; developing a regional strategy; or building in program evaluation only in areas with sufficient population to be statistically significant.
- Funds allocated for a specific program should be used to implement that program. Evaluation and reporting requirements must be reasonable.
- Contract deliverables, program and reporting requirements must be consistent with the allocation amount.

# APPENDIX 10: EVOLVING ROLES TO SUPPORT INFORMATION TECHNOLOGY FOR PUBLIC HEALTH

The new technologies that make information collection, processing, and exchange more efficient for public health agencies also require new staff responsibilities. The Information Technology Committee has identified the following roles and activities that must be present in every agency to keep information systems efficient and secure.

## Technology roles for agency administration and management

- Assign roles for agency and clearly communicate expectations; provide guidance and guidelines.
- Develop a coordinated approach to approve individuals for access to specific applications and to approve the “rights” to be granted each individual for each application (i.e., types of rights, application administrators, supervisor access for monitoring program or employee performance, user-only, etc.). Decide who in the agency—among supervisors, managers, and program directors—will approve individuals for access to specific applications and who will communicate this information to the state Department of Health.
- Decide who will go to which trainings and how often.
- Decide and approve how much of which type of equipment to acquire.
- Decide and approve use policies—expectations, monitoring, and consequences regarding security, timeliness, accuracy, accountability, and acceptable behavior regarding use.

## Technology roles that might be assigned to the IT manager

- Decide how much of which type of equipment to acquire.
- For individuals approved for access and specific rights to specific applications, arrange for necessary and appropriate equipment, security tools such as digital certificates, training, etc., and communicate this information to the state Department of Health.
- Maintain the list of who has access, and the specific rights granted, to which applications. Communicate this information, as appropriate, routinely to state Department of Health.
- Maintain a tracking system that includes 1) who has been granted access and which type of rights to what; 2) who has signed the necessary paperwork, such as security and confidentiality statements and data-sharing agreements; 3) who has been trained in what and who is due for training; 4) when each digital certificate expires or needs to be renewed, etc. Communicate this information, as appropriate, routinely to state Department of Health.
- Maintain current contact or profile information, such as accurate e-mail addresses for each user. Manage a reminder system to queue employees to update their own contact information and profile. Communicate this information, as appropriate, routinely to state Department of Health.
- Maintain a collection of current policies regarding data access and a current list of who may grant approval.

- Serve as information coordinator in assuring that once an employee has been appropriately approved for access to an application, the agency's application administrator or technical staff make the appropriate changes.
- Assign individuals to "administer" the application within the agency or region—i.e., with WaSECURES and LMS, local health jurisdictions will administer and manage their own use of the application. This will require significant training and frequent (sometimes daily) work with the application.
- Serve as main point of contact for the local health jurisdiction in communications with the state Department of Health application, program, or technical staff.
- Serve as the agency technical resource for the specific application.
- Provide general technical resource per agency policy.

### Technology roles that might be assigned to human resources or quality improvement or assurance managers

- Develop a coordinated approach to approve individuals for access to specific applications and to approve the "rights" to be granted each individual for each application (i.e., types of rights, application administrators, supervisor access for monitoring program or employee performance, user-only, etc.). Decide who in the agency—among supervisors, managers, and program directors—will approve individuals for access to specific applications and who will communicate this information to the state Department of Health.

- Maintain current contact or profile information, such as accurate e-mail addresses for each user. Manage a reminder system to queue employees to update their own contact information and profile. Communicate this information, as appropriate, routinely to state Department of Health.
- Maintain collection of current policies regarding data access and a current list of who may grant approval.

### Technology roles needed at the State Department of Health

- Establish a single point of contact to learn about each application—technical specifications, equipment and security requirements, user and administrator training, access help desk resources, types of rights available for users, etc.
- Establish a single point of contact for local health jurisdictions to arrange for necessary and appropriate equipment, security tools such as digital certificates, training, etc.
- Establish a single point of contact for local health jurisdictions to communicate changes in individuals approved access.
- Coordinate an approach for maintaining a tracking system and providing routine reports to local health jurisdiction leadership that includes 1) who has been granted access and which type of rights to what; 2) who has signed the necessary paperwork such as security and confidentiality statements and data-sharing agreements; 3) who has been trained in what and who is due for training; and 2) when each digital certificates expires or needs to be renewed.

# APPENDIX 11: PHIP SYSTEM-LEVEL COMPETENCIES

## New coalitions and alliances

- Analyze information and influence diverse groups to participate in public health activities.
- Identify potential strategic partners.
- Facilitate and form various work groups, alliances, and coalitions, and use community mobilization methods and tools appropriate to the local community.
- Foster trusting and effective relationships with diverse groups.

## Communication

- Manage information dissemination to diverse entities including the public, legislators, local boards of health, and the news media.
- Interact with the public and the media especially with regard to risk communication.
- Balance legal and confidentiality issues for the public benefit.
- Use the most effective, efficient, and expedient telecommunications media for individual public health situations.

## Results-based accountability system

- Develop a strategic plan that identifies goals, objectives, and performance measures and has a process to monitor and evaluate achievements.
- Develop, maintain, and evaluate:
  - \* Operating infrastructure (accounting, budget, contracts, procurement, grants compliance, facilities, and risk management systems)
  - \* Program and administrative written policies, procedures, and protocols

- Use program evaluation and cost efficiency tools (cost benefit analysis, return on investment tools) to monitor and evaluate effectiveness of results and adjust as indicated.
- Evaluate resource utilization.

## Information technology systems

- Enable collection and access to information on current health topics, demographics (including vital statistics), and health outcome indicators.
- Implement data collection processes that ensure technology transmission compatibility and systems storage. Processes should also assure access to client treatment and case management plans, current health topics and updates, and community demographic and infrastructure information.
- Provide information in user-friendly formats in a timely manner.
- Guide the collection, analysis, and dissemination of health status information.
- Collect, analyze, and organize data and information for staff, public health partners, and clients.
- Use software available within the agency to perform research, record keeping, communication (e.g., e-mail, word processing programs), data analysis and interpretation (including simple spreadsheet programs), and reporting tasks.
- Use web-based applications for searching and retrieving information.

## Technical and professional competencies

- Create an environment that embraces workforce development methods to build staff capacity through continuous learning opportunities.
- Apply workforce development principles (personnel rules, compensation, employee policies).
- Use commonly applied workforce development tools (needs assessment, training, learning and development plans, evaluations, etc.) and apply as needed to develop staff.
- Identify and apply current relevant scientific and technical information.
- Apply the consultation process to differing aspects of the internal and external consultant roles as appropriate to the situation and stakeholders.
- Model and encourage creativity and vision in the application of technology to improve services and productivity.
- Improve knowledge, skills, and abilities to improve performance in the short-term and long-term.

## Public health policy, authority, and responsibility

- Apply and practice leadership principles and skills.
- Analyze, evaluate, and communicate public policy choices.
- Interpret and apply laws and regulations that pertain to public health authority and responsibility.
- Apply an understanding of the value and costs of public health services to make strategic decisions regarding funding choices.

## Quality improvement

- Apply strategic quality improvement methodologies that are aligned with program goals, stakeholder input, etc.
- Evaluate needs and develop a quality improvement plan.
- Foster an environment where quality improvement is embraced and applied as part of everyday work.

## Systems thinking

- Understand the need to see interrelationships rather than cause-effect chains; evaluate key stakeholder interests to find commonalities that benefit the public health system.
- Be proactive and manage the processes of change.
- Promote and facilitate organizational learning.
- Be creative and flexible in identifying and evaluating alternatives, and anticipate the consequences of actions and responses.
- Optimize opportunities to improve the health status of the community.
- Demonstrate ability to address problems with new and effective solutions.

## Visionary leadership

- Define key values and use these principles to guide action.
- Participate in scanning the environment, internally and externally, for information critical to the agency's mission.
- Keep the mission in focus and articulate it clearly.
- Facilitate creation of a vision of excellence and a scenario of a preferred future.
- Allow others to be empowered to create and implement plans to enact the shared vision.
- Coach, inspire, and motivate staff and others to accomplish agency mission.



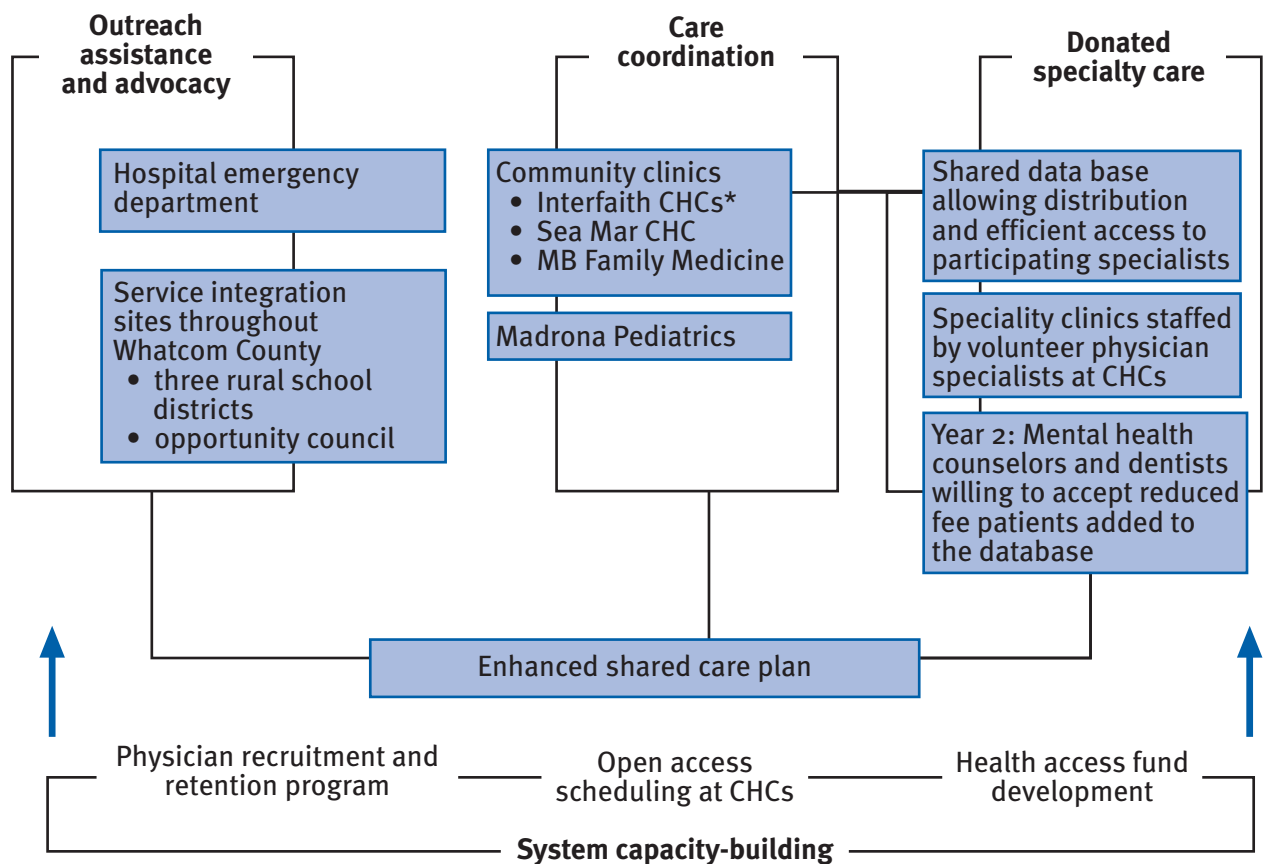
# APPENDIX 12: IMPROVING ACCESS TO CARE IN WHATCOM COUNTY

The Whatcom Alliance Access Project will increase access to care and improve quality and cost effectiveness of care for uninsured and underserved people in Whatcom County. Project goals and objectives are:

- Consumer outreach assistance and advocacy;
- Coordination of care and case management for people with chronic illness, high-risk individuals, and high utilizers;
- Centralized access to specialty care for uninsured people, using managed, donated services;
- System capacity-building for community health centers through advanced access scheduling and recruitment and retention for private medical practices.

The following diagram shows key activities and the roles community entities will play.

## Care Integration and System Capacity-building For Uninsured and Under-insured People in Whatcom County, WA



\*CHC = community health center



# THE CORE FUNCTIONS OF PUBLIC HEALTH

Public health officials focus on “what we as a society do collectively to assure the conditions in which people can be healthy” (Institute of Medicine, 1988). The field of public health seeks to mitigate factors that threaten people’s health and works to create conditions that improve or promote good health. In this way, public health services are “population-based.” These services can be organized into three “core functions,” as described below.

## Health Assessment

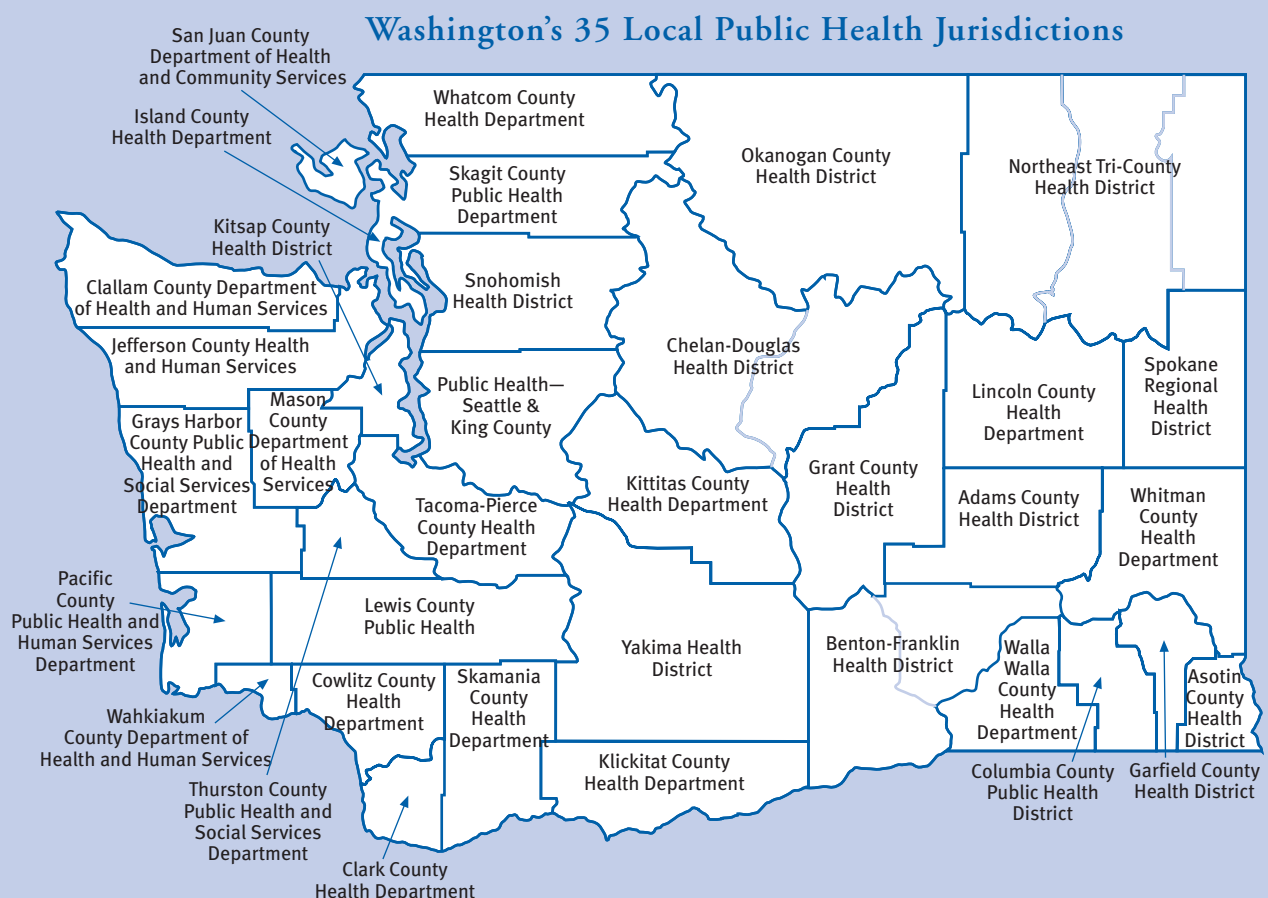
Helps us determine how, where, and when health threats are occurring. It includes collection, analysis, and dissemination of information on health status, incidence of health problems and risks, choices about health behavior, environmental health concerns, availability and quality of services, and the concerns of individuals.

## Policy Development

Used to set a course for specific action or regulation to improve or protect health. It may involve a formal public process, as with a local board of health. Private organizations and citizen groups also develop public health policy.

## Assurance

Means making sure the right things happen—that we have the health information we need, that we adhere to the policies we have chosen, and that needed services are available. Government programs often play an assurance or oversight role, but they do not provide all the needed services.



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